

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79-10606							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERONICA ADAMS				2a. DATE OF DEATH MONTH DAY YEAR 5/25/79		2b. HOUR 9:08 AM			
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 4 27 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cham.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL CONVALESCENT CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2409 Arbuton Ave. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Woods				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine A. Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-10-6819		17. INFORMANT ADDRESS William J. Adams 2409 Arbuton Ave 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCUD. CUA.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/25/79, 1979, to 5/25/79, 1979, that (I) (we) last saw the deceased alive on 5/25/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ruth K... 22d. PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22e. ADDRESS 313 Hospital Drive Glen Burnie Md.				22c. DATE SIGNED 5/25/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5-28-1979		23c. NAME OF CEMETERY OR CREMATORY Linda Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. Ind.			
24. FUNERAL DIRECTOR NAME John Cowan				ADDRESS 901 Hallmark Dr.		25a. DATE REGD. BY REGISTRAR MAY 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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(M)

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10607

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR DST	
SAMUEL		Collings AMOSS, JR.		MAY 3, 1979		12:55P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN
Male	White	Sept. 24, 1921		57			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Sales Mgr. (ret)		Chesapeake Dist.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS		
Maryland		A.A.	Severna Park		111 Southway 21146		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Samuel C. Amoss Sr.		Helene Shannahan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (wife) ADDRESS			
Yes		W.W.II 218-14-9583		Same as #13 Mrs. Dorothy E. Amoss			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor 2396 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Drugs							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF BIRTH, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. certify that (I) (this hospital) attended the deceased from 5/2/79 to 5/3/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
23a. SIGNATURE OF PHYSICIAN NAME (TYPE OR PRINT)		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED	
JORGE B. RAMIREZ, M.D.		M.D.				5/3/79	
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. DATE		23d. NAME OF CEMETERY OR CREMATORY		23e. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May, 7, 1979		Druid Ridge Cem.		Pikesville, Balto. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home		Glen Burnie, Md.		MAY 8 1979		[Signature]	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR		REG. NO. 79-10608 DST	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH DAY YEAR	
BESSIE		V.		ANDERSON				MAY 10, 1979	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Negro		Oct 14, 1904		74		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
S.C.		U.S.A.				ANNE ARUNDEL COUNTY		MD	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Housewife					
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN					
Md.		Montgomery		Damaschus		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route # 1	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Mose Wardlaw		Victoria Wideman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				William Wardlaw		461 W. 148th ST NY, N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CHF									
4140 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) ASHD-									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
22a. INJURY OCCURRED		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET					
				4/11/79		5/10/79			
23. I, certify that (I) (this hospital) attended the deceased from 4/11/79 to 5/10/79, that (I) (we) last saw the deceased alive on 5/10/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased was not seen by the body after death)									
24. SIGNATURE		DEGREE		25. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		26. DATE SIGNED			
Jorge B. Ramirez, M.D.						5/10/79			
27. PHYSICIAN'S NAME (TYPE OR PRINT)		28. ADDRESS							
JORGE B. RAMIREZ, M.D.		325 HOSPITAL DR., GLEN BURNIE, MARYLAND							
29a. BURIAL, CREMATION, REMOVAL (SPECIFY)		29b. DATE		29c. NAME OF CEMETERY OR CREMATORY		29d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		5-16-79		Purdham Cemetery		Monrovia		md.	
30. FUNERAL DIRECTOR		31. ADDRESS		32. DATE REC'D. BY REGISTRAR		33. REGISTRAR'S SIGNATURE			
George R Snowden		246 N. WASH. ST Rockville Md.		MAY 21 1979		P. H. Kennedy			

10-1000000

RECEIVED MAY 10, 1978 ANDERSON V. BASSIE

CHEN BURNIE NORTH ARUNDHEL HOSPITAL ANNE ARUNDEL COUNTY

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CHEN BURNIE NORTH ARUNDHEL HOSPITAL ANNE ARUNDEL COUNTY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VNR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10609

1. STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
ELLA		ANDERSON	
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) YEARS MONTHS DAYS
female	white	5 15 09	70
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	USA	NEVER MARRIED DIVORCED	Anne Arundel County
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Owings	Box 6	housewife	-
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
MD.	A.A.	Owings	13e. STREET ADDRESS Rural Box 6
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Harry Stallings		Hattie Sears	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
no	578-03 4551	Virginia Gibson Bx 63 Dentist Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>Gunshot wound of chest</u> IMMEDIATE CAUSE (a) <u>9554</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>9554</u> (c) <u>9554</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-13-19 79	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Box 6 Owings Anne Arundel Md.	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Ann M. Dixon</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		DATE SIGNED 5-15-79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-17-79	23c. NAME OF CEMETERY OR CREMATORY Southern Mem. Gardens
24. FUNERAL DIRECTOR NAME Rausch Funeral Home		23d. LOCATION CITY OR TOWN Dunkirk	23e. COUNTY Cal. Md.
ADDRESS Owings Md.		25a. DATE REC'D. BY REGISTRAR MAY 24 1979	25b. REGISTRAR'S SIGNATURE <u>H. J. McCreedy</u>

00901-01

(M)

OFFICE OF THE

ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 10, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10610

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
KEITH R. BEGGS					MAY 19, 1979				12:45AM
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Caucasian	July 16, 1902			76	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Wisconsin	USA				ANNE ARUNDEL MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Severn	1855 QUEBEC CT, SEVERN, MD			Store Owner		Retired			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Md.	AA	Severn	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1799 Montreal Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Frank		Margaret							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		390-32-2164		Mrs. Aileen Beggs, wife, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypercalcemia</u> <u>2320</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hyperparathyroidism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>4 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>79</u> , to <u>May 9</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE			22c. DATE SIGNED		
<u>James L. George</u>				M.D.			5/19/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>James L. Abbruzzese</u>				Hopkins Hospital, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		23May79		Graceland Cemetery		Clintonville, Wisconsin			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS James S. Kirkley, Glen Burnie, Md.				MAY 22 1979		<u>Jeffrey Belvidere</u>			

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U.S. GOVERNMENT PRINTING OFFICE: 1967

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10611

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Russell Glen Bennett			2a. DATE OF DEATH MONTH DAY YEAR May 31, 1979		2b. HOUR 11:00p				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Pittsburg, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Toolmaker		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b. CITY OR TOWN AA		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 1 Thomas Road		
14 FATHER'S NAME FIRST MIDDLE LAST Edward Bennett			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Rogers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Mrs. Anna Bennett, wife, same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transitional Cell Carcinoma of the Bladder 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metastasis to the Prostate and Ureters (c) Ureters APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital attended the deceased from August 76 to May 31 , 19 79 , that (1) (we) lost saw the deceased alive on April 23 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not see the body after death.									
22b. SIGNATURES <i>Paul Bormel</i>						22c. DATE SIGNED 1 June 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Bormel, M. D.						22e. ADDRESS 3350 Wilkens Ave., Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4 June 79		23c. NAME OF CEMETERY OR CREMATORY Homewood Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburg, Alleghany, Pa.			
24 FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE <i>F. J. H. H. H.</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• *et seq.*

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10612

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) WESLEY Thomas BLOCKSTON		2a DATE OF DEATH MONTH DAY YEAR 5 2 79		2b HOUR 1:05 P.M.	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR June 3, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10 CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b KIND OF BUSINESS OR INDUSTRY Davidson Chem. Co.
13a STATE Maryland	13b COUNTY AnneArundel	13c CITY OR TOWN GlenBurnie	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 8083 Solley Road	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN BLOCKSTON		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Thomas			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 215-07-7678		17 INFORMANT ADDRESS Same as # 13 Mrs. Anna M. Helferstay (Daughter)	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS CVA DUE TO, OR AS A CONSEQUENCE OF (c) 10 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I (this hospital) attended the deceased from 5-30-79 to 5-2-79 that I (we) lost saw the deceased alive on 5-2-79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) did not view the body after death.					
22b SIGNATURE MB [Signature]		DEGREE PHYSICIAN		22c DATE SIGNED 5-2-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. HOPKINS		22e ADDRESS 5400 Old coast rd Bethesda MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4 MAY '79		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.		25a DATE REC'D. BY REGISTRAR MAY 8 1979			
24 FUNERAL DIRECTOR NAME G. N. Hopkins		ADDRESS SINGLETON FUNERAL HOME, GLEN BURNIE, MD.		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post returned by the hospital or attending physician.

BP

19-10015

Wesley Jones & Associates
1775 W. 1st Avenue, Suite 100
Portland, Oregon 97201
Phone: 503-228-1111
Fax: 503-228-1112
E-mail: wesley@wesleyjones.com
www.wesleyjones.com

19-10015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10613

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ernest Salanda Booth			2a. DATE OF DEATH MONTH DAY YEAR 5-7-79			2b. HOUR 8:00A.	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Aug. 5 1910		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AACO MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 314 Chester Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BOOTH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE PINKNEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-12-9248A		17. INFORMANT ADDRESS DAISY BOOTH 314 Chester Ave. Annapolis, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung - Metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH app. 6 mo.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Remote CVA 2° to HCVAD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1979 Jan. 19 , to May 7th 1979 , that (I) (we) last saw the deceased alive on April 29th 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Errol A. Phillip				22c. DATE SIGNED 5-8-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERROL-A-Phillip	
22e. ADDRESS 20 Ridgely Ave, Ann Md 21401				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-11-79		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR MAY 11 1979		25b. REGISTRAR'S SIGNATURE History Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100-10613



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-pen pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-10614			
1. DECEASED NAME (TYPE OR PRINT) Susan m Bowen			2a. DATE OF DEATH MONTH DAY YEAR May 24 1979			2b. HOUR 10:35 P.M.							
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 17 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.							
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 806 CHESAPEAKE AVE.				
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES SMITH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE LEE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 22-526063D			17. INFORMANT ADDRESS E. Grayn Bowen Jr. 308 RIVERVIEW AVE. ANNAPOIS, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) peripheral arterial occlusive disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): peripheral arterial occlusive disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JAN 2 1976, to MAY 24 1979, that (I) (we) last saw the deceased alive on MAY 24 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE MW Goodman MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED May 25 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MW GOODMAN			22e. ADDRESS 104 Forbes St. Annapolis Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-27-79		23c. NAME OF CEMETERY OR CREMATORY HILLCREST			23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOIS A.A. md.					
24. FUNERAL DIRECTOR NAME JOHN M. TAYLOR & SONS						ADDRESS ANNAPOIS, md.		25a. DATE REC'D. BY REGISTRAR MAY 29 1979				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. STATE REGISTRAR		FOR		REG. NO. 79-10615					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harvey Brown Bowman				2a. DATE OF DEATH MONTH DAY YEAR May 16, 1979		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH Brooklyn Pk.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5203 Patrick Henry Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5203 Patrick Henry Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Bowman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 215 16 0876		17. INFORMANT ADDRESS 836 Cove Terrace Phillip C. Bowman Arnold, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 PROGRESSIVE CEREBRAL METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA OF THE LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 5/8 11 19 78 to 5/8 19 79, that (I) (we) last saw the deceased alive on 5/8 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard C. Stephenson				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD C. STEPHENSON				22e. ADDRESS BCRC 22 S. Green St. Balto, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/18/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Anne Arundel Md.			
24. FUNERAL DIRECTOR NAME George J. Gonce				ADDRESS 4001 Ritchie Highway		25a. DATE REC'D. BY REGISTRAR MAY 21 1979		SIGNATURE	

9-10612

Report of Police 1001 Alameda Highway, MAY 2 1979

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 79-10616 EDT
2b. HOUR 4:43 A.M.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		A.M. P.M.	
PEARL Louise BRANHAM		MAY 3, 1979		4:43 A.M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	white	MONTH DAY YEAR	57	MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U. S. A.		ANNE ARUNDEL COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Housewife		own home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	A. A.	GlenBurnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	311 5th. Ave.S.E.	
14 FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
William A. Luckett	Mary Lou Farington		No N/A		
16b. SOCIAL SECURITY NO	17 INFORMANT (husband) ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 5711		
213-20-7886	Mr. Lois Alvin Branham		DUE TO OR AS A CONSEQUENCE OF		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above (time) (date) (did not) see the body after death.	22b. SIGNATURE DEGREE				
	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
ANASTACIO E. SUBONG, M.D.	1406 CRAIN HIGHWAY, SUITE 102 GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	May 7, 1979	GlenHaven Mem. Pk.	CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Singleton Funeral Home, GlenBurnie, Md.	MAY 8 1979				

10-10616

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 20M
(VRA 15, 4) 7/781 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10617

1. DECEASED NAME (TYPE OR PRINT) <i>Alberta M. Brent</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5/30/79</i>		2b. HOUR <i>1:29 AM</i>
3. SEX <i>F</i>	4. RACE <i>N</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8/16/19</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	7. AGE (IF UNDER 1 YEAR) MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY MD.</i>	
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>	13b. COUNTY <i>A.A.</i>	13c. CITY OR TOWN <i>SHADYSIDE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>Columbia Beach Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>NEBRASHA DENNIS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SELINA DUPPEN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>	16b. SOCIAL SECURITY NO <i>214-16-6334</i>	17. INFORMANT ADDRESS <i>BESSIE BROWN Shadyside, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Cholecystitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>1 wk</i> <i>Years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Renal Failure 20 D.M.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>5/25/79</i> 19 <i>79</i> , to <i>5/30/79</i> 19 <i>79</i> , then (1) (we) lost saw the deceased alive on <i>5/29/79</i> 19 <i>79</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Joseph N. Friend</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5/30/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph N. Friend</i>		22e. ADDRESS <i>1616 Forest Dr. Annapolis, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>6-2-1979</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Pauls Ceme.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Shadyside Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>WILLIAM REESE & SONS MORTUARY P.A. Annapolis, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 31 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert Kennedy</i>	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST		MONTH DAY YEAR				M			
Charles D. Brigerman		May 22 1979							
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	MONTH DAY YEAR	68 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Co. MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Pasadena		Home = Box 324 204th Street				Ship Fitter		Shipyard	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Md.		A.A.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 324 204th St.	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Joseph Howard Brigerman				Mary Ann Johnson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Yes				W.W. II		Balto 21225			
				217 03 7468		Catherine Schneider 5717 Moor St.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4029 Cardiac decompensation due to									
DUE TO, OR AS A CONSEQUENCE OF (b)								Hypertensive heart disease	
DUE TO, OR AS A CONSEQUENCE OF (c)								12 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
none									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from May 10, 19 56, to May 22, 19 79, that (I) (we) last saw the deceased alive on April 15, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.									
22b SIGNATURE				DEGREE				22c DATE SIGNED	
R. M. McLaughlin, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				5/22/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
R. McLaughlin				Pasadena, Md. 21122					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/25/79		Cedar Hill Cem.		Brooklyn A.A. Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
George J. Gonce				Balto 21225		MAY 25 1979		R. J. Gonce	
4001 Ritchie Hwy									

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **79-10619**

**1- FOR
STATE
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT)		FIRST Keith		MIDDLE William		LAST Broersma		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH 5/31		DAY 19		YEAR 79		7b. HOUR M	
3 SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1949		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 30 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 5/31		MONTH DAY YEAR 19 79		7d. HOUR 1:14	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.											
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Signalman				12b. KIND OF BUSINESS OR INDUSTRY B & O RR					
13a. STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 98 Lake Shore Drive							
14. FATHER'S NAME FIRST MIDDLE LAST William Keith Broersma						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Geigen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Judy Broersma Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:15xx 5/31 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in multi auto collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dorsey Rd/Rt 170 Anne Arundel Co, MD									
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5/31/79					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/4/1979		23c. NAME OF CEMETERY OR CREMATORY Druidridge Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Mc Cullt F.H. Mountain & Pick Neck Rds, Pgs. Md. 21122										25a. DATE REC'D. BY REGISTRAR JUN 1 1979				25b. REGISTRAR'S SIGNATURE L. H. McCready			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

91801-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-10620	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOBY URIAS BROOKS				2a DATE OF DEATH MONTH DAY YEAR 5-26-79			2b HOUR 11:00 M		
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 11 26 05		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH (Baltimore) Glen Burnie, MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE MD		13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1110 North Crain Hwy			
14 FATHER'S NAME FIRST MIDDLE LAST Urias Brooks Sr		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Oliver									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO OR UNKNOWN <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 213-10-8642		17 INFORMANT Allene Brooks				ADDRESS 1110 Crain Highway			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Respiratory Arrest 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b): Pancreatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD & Embolic Pt. Cerebral infarct											
19a DATE OF OPERATION 5-15-79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Explor. Lap. Gastrostomy				19c AUTOPSY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 5-26-79 to 5-26-79 , that (I) (we) lost saw the deceased alive on 5-26-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE L.R. Arquillano		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED 5/26/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) L.R. ARQUILLANO				22e ADDRESS SBGH 3001 S. Hannover							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/30/79		23c NAME OF CEMETERY OR CREMATORY Carver Mem. Pk		23d LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland					
24 FUNERAL DIRECTOR NAME Law Funeral Home				ADDRESS 4611 Park Heights Ave.		25a DATE REC'D. BY REGISTRAR JUN 1 1979		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP _____

100-10000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. TIME		79-10621 D.S.T.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. TIME		MAY 20, 1979 5:40 A			
FRANK JAMES BROWN		MAY 20, 1979		5:40 A					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male	Caucasian	Oct. 25, 1918	60	MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA		ANNE ARUNDEL COUNTY		MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Carpenter						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Md.	AA	Severn	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8283 Quarterfield Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Frank J. Brown		Susan Beatty							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		WW 2		Mrs. Lola Brown, Wife, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral infarct, left parietal, 4140									
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct, old, extensive, septal									
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis of Heart Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/17/79, to 5/20/79, that (I) (we) last saw the deceased alive on 5/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Glenn F. Robbins		M.D.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
GLENN F. ROBBINS, M.D.		PYRAMID BUILDING SUITE 300 1404 CRAIN HWY. GLEN BURNIE, MD 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		23 May 79		Glen Haven Mem.		Glen Burnie, AA... Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME James S. Kirkley, Glen Burnie, Md.		MAY 22 1979		[Signature]					

18-1083
D.S.T.

FRANK	JAMES	BROWN	MAY 20, 1939	5:40 A
also	Canadian	500.25, 1918	80	
US	USA	x	ANNE ARUNDEL COUNTY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL	Colchester		
10.	Government	x	5000, vermouth 1908	
Frank	STORM	usm	James	
50	500-1000	100. 1000, 1000, 1000		

[Faint, illegible handwritten notes and stamps covering the middle section of the page.]

GLENN F. ROBBINS, M.D.
FROM GRAIN HWY. GLEN BURNIE, MD 21031
PYRAMID BUILDING SUITE 200
MAY 20 1939
James F. Robbins, Glen Burnie, Md.
52-407 70 Glen Burnie, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10622

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIAN G. BROWN			2a. DATE OF DEATH MONTH DAY YEAR MAY 26 1979		2b. HOUR A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG 31 1904	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 577 RIDGLEY AVE.		12a. USUAL OCCUPATION HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE MD.			13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN F. JONES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS ANDREW H. BROWN #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Kidney, Metastatic 1990 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE James David Biles MD.		DEGREE MD.		22c. DATE SIGNED 28 May 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James David Biles MD.		22e. ADDRESS 100 RIDGLEY AVE. ANNAP. MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-28-1979	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD.	
24. FUNERAL DIRECTOR NAME JOHN M. TAYLOR-SOXS		ADDRESS ANNAPOLIS MD		25a. DATE AND BY REGISTER MAY 28 1979	



The following is a list of the
 names of the persons who
 have been appointed to the
 various positions in the
 office of the Secretary of the
 State of New York, for the
 year 1855.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-10623	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anne Marie Bueneman				2a. DATE OF DEATH MONTH DAY YEAR 5-10-79				2b. HOUR 5:46 M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12-7-04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel, MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1781 Shaftsbury Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST William Rudolph		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Schneider									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-1451		17. INFORMANT ADDRESS Ervan Bueneman (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2051 Chronic Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from August 19 78, to 5/10 79, that (I) (we) last saw the deceased alive on 5/19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ervan W. Cole III				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/10/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENSER W. COLE III				22e. ADDRESS 121 CATHEDRAL ST ANNAPOLIS Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-16-79		23c. NAME OF CEMETERY OR CREMATORY United Ch. of Christ Cem. Jamestown		23d. LOCATION CITY OR TOWN COUNTY STATE Missouri					
24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Anna., Md.				25a. DATE REC'D. BY REGISTRAR MAY 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

BP

10-10623

RECEIVED
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U.S. DEPARTMENT OF AGRICULTURE



Field Station

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10624

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
		FIRST MARY E LAST BURGESS				MONTH DAY YEAR 5-4-79				2:48 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7-31-82		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel, MD.							
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 923 Jackson Street					
14. FATHER'S NAME FIRST MIDDLE LAST Filmore Windsor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-74-8348		17. INFORMANT ADDRESS Ethel Ford Schmitt (same as 13e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>1 wk</u> <u>1 wk</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Renal failure</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>5/3</u> 19 <u>79</u> , to <u>5/4</u> 19 <u>79</u> , that (1) (we) lost <u>5/3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) <u>view the body after death</u>													
22b. SIGNATURE <u>Joseph N. Friend M.D.</u>				DEGREE M.D.		22c. DATE SIGNED 5/4/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph N. Friend</u>				22e. ADDRESS <u>1616 Forest Dr. Annapolis, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>05-05-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis, Anne Arundel, Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u> ADDRESS <u>1212 West St., Anna., Md.</u>				25a. DATE FILED BY REGISTRY <u>MAY 7 1979</u>				25b. REGISTRY SIGNATURE <u>[Signature]</u>					

2-10854

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 79-10625				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Winford Burke					2a DATE OF DEATH MONTH DAY YEAR May 5, 1979				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		2b HOUR 11:27 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 665 Cedar Dr.	
14 FATHER'S NAME FIRST MIDDLE LAST James McDonald		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Burke							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. -- -- 217-62-7555		17 INFORMANT ADDRESS Rosemary Schueler same as 13 e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 434- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis - DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure - Myocardial infarction									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 325 Hospital Drive, #207 Glen Burnie, Md. 21061					
22a. I certify that (I, this hospital, attended the deceased from 5/13/79 to 5/15/79, 19, that (I) (we) last saw the deceased alive on 5/13/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)									
22b. SIGNATURE Jorge B. Ramirez, M.D.		22c. DATE SIGNED 5/16/79		22d. ADDRESS 325 Hospital Drive, #207 Glen Burnie, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24 FUNERAL DIRECTOR NAME McCully Funeral Home		ADDRESS Balto., Md. 237 E. Patapsco Ave.		25a. DATE REC'D. BY REGISTRAR MAY 7 1979		25b. REGISTRAR'S SIGNATURE Patricia Helms			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-10626	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST LOUVINIA		MIDDLE		LAST BURLEY		2a. DATE OF DEATH MONTH DAY YEAR 5-5-79		2b. HOUR 8:45 M	
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR March 26 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 303 President Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 303 President Street			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. JOHNSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES QUEEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Irene McDowell 303 President Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>101 B. CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Renal insuff.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> 19 <u>78</u> , to <u>5-5</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5-5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jayce W. Allen</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/9/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYCE W. ALLEN		22e. ADDRESS 111 CATHEDRAL ST									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-10-79		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NAT. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland					
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>					

2-10050



MAILED 10-10-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-10627	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Marion F. Burton				2a DATE OF DEATH MONTH 5 DAY 13 YEAR 79		2b. HOUR 7 45 PM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH 11 DAY 14 YEAR 89		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10 CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Shady Side		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1800 Maryland Avenue	
14. FATHER'S NAME FIRST Samuel G. MIDDLE Burton LAST Burton				15. MOTHER'S MAIDEN NAME FIRST Emily MIDDLE R. LAST Ressiker							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) not known		17 INFORMANT Harold F. Burton		ADDRESS 311 Woodland Way Romney, West Virginia					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured ventricular septum DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 5/13/79 to 5/13/79 , that (1) (we) last saw the deceased alive on 5/13/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE Georg C Samaras		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Georg C Samaras		22e. ADDRESS 1616 Forest Drive									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 17, 1979		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Prince Georges, COUNTY Maryland STATE					
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		ADDRESS 5130 Wisconsin Ave., N.W. Wash., D. C. 20016		DATE RECD. BY REGISTRAR MAY 18 1979		REGISTRAR'S SIGNATURE [Signature]					

79-10827

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10628

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY Emory BUSSEY			2a. DATE OF DEATH MONTH DAY YEAR MAY 21 1979			2b. HOUR DST 1:22P M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 3 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1308 North Road	
14. FATHER'S NAME FIRST MIDDLE LAST Mitchell Emory				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Watts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218.05.9641		17. INFORMANT ADDRESS Mr. James T. Bussey (Husband) as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chr Lung disease DUE TO, OR AS A CONSEQUENCE OF (c) ASH CVD, ENF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-12-1979 , to 5/21/1979 , that (I) (we) last saw the deceased alive on 5-21-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Eren						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 21, 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SACIT EREN, M.D.						22e. ADDRESS 529 S. CAMP MEADE ROAD LINTHICUM, MARYLAND 21090				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 24, 79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR MAY 22 1979		25b. REGISTRAR'S SIGNATURE History McCreedy		

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9-10050

(M)

Female	White	June 3 1911	87
Virginia	USA	X	
Married	AA	1508 North Road	
Michell	2301V	Office	Water
Long	215.05.2541	Mr. James T. Sweeney (husband)	22 12

Handwritten notes and signatures are present in the lower half of the page, including a large signature that appears to read "James T. Sweeney".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10629

1. DECEASED-NAME (Type or print) Daniel First A. Middle Carr Last		2a. DATE OF DEATH 5 Month 9 Day 79 Year		2b. HOUR 3:50 P.M.
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 5 15 1905		6. AGE (In years last birthday) 73 YRS.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ANNE ARUNDEL COUNTY Md.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1401 York Town Rd.
14. FATHER'S NAME First WILLIAM Middle CARR Last		15. MOTHER'S MAIDEN NAME First ALICE Middle WRIGHT Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO [If yes give war or dates of service]		16b. SOCIAL SECURITY NO. 213-12-0637	17. INFORMANT EVELYN CARR 1401 York Town Rd. Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Expanding Abdominal Aortic Aneurysm				
19a. DATE OF OPERATION 5-10-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 79 , to 5-9 , 19 79 , that (I) (we) last saw the deceased alive on 5-9 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE R. Holseult M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 5-9-79
22d. PHYSICIAN'S NAME (Type) R. HOLSEULT				22e. ADDRESS 104 Forbes St. Annapolis
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-15-79	23c. NAME OF CEMETERY OR CREMATORY ASBURY BROADNECK CHURCH CEME. St. Margarets, Maryland	
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. Md.		25a. REC'D BY REGISTRAR DATE MAY 11 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady

83801-01

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315



MAY 11 1961

ADJUTANT GENERAL'S OFFICE
WASHINGTON, D. C. 20315

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10630

1. DECEASED NAME (TYPE OR PRINT) Baby CLARK, (Sarah J. Clark)			2a. DATE OF DEATH MONTH DAY YEAR 5 4 79		2b. HOUR 10 ²⁴ A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 3 79	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS — 1 1		IF UNDER 1 YEAR IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 731 Cypress Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Dale C. Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —	17. INFORMANT Dale C. Clark - Sec. 13.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Distress, failure</u> 7705 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Atelectasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> 19 <u>79</u> , to <u>5-8</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Stanley R. Weimer, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-4-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley R. Weimer, M.D.		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-7-79	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD.
24. FUNERAL DIRECTOR NAME Robert S. Barranco - Severna Park		25a. DATE PREPARED BY REGISTRAR MAY 9 1979	25b. REGISTRAR'S SIGNATURE [Signature]

50-10630

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-10631 REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST <i>Collison Alice Virginia Collison</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>5/31/79</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-26-00</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>78</i>	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen. Hosp.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Richard Edwards</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carnie Elizabeth Hulst</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-01-3826</i>		17. INFORMANT ADDRESS <i>Joan Reece, 300 Delma Ave. Pas. Md. 21122</i>	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>H & ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Degenerative Joint Disease.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).					
19a. DATE OF OPERATION <i>5-31-79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Severe Degenerative Joint Disease.</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>5-31-79</i> to <i>5-31-79</i> that (2) we last saw the deceased on <i>5-31-79</i> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Arnold G. Alexander, M.D.</i>		22c. DEGREE <i>M.D.</i>		22d. DATE SIGNED <i>5-31-79</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arnold G. Alexander M.D.</i>		22f. ADDRESS <i>Anne Arundel Gen. Hosp. Annapolis, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-4-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maple Meth. Church Cem.</i>	
23d. LOCATION CITY OR TOWN <i>Annapolis</i>		23e. COUNTY <i>Anne Arundel</i>		23f. STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Mc Cully F. H. of Pas. Mountain & Tick Neck Rds.</i>		24b. ADDRESS <i>Pas. Md. 21122</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. McCuskey</i>					

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REG. NO. 79-10632

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH		5 DAY		22 YEAR		1979		2b. HOUR		11:35	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1927		6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 5 MONTH 22 DAY 19 YEAR 79											
1e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				1b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.									
1d. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mason				12b. KIND OF BUSINESS OR INDUSTRY Construction					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Carroll				13c. CITY OR TOWN Sykesville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 5721 Bartholomew Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Costley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva Collins																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216 30 2883				17. INFORMANT Mildred L. Costley Sykesville, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00A 5 21 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) struck by auto while working on road bed													
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Jennifer Road Anne Arundel Maryland													
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Margareta Ore Korell				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5/23/79									
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-25-79				23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.									
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 28 1979				25b. REGISTRAR'S SIGNATURE Dorothy McCreedy									

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

10-10833



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10633

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carrie Virginia Pack Cowan			2a. DATE OF DEATH MONTH DAY YEAR May 7 1979			2b. HOUR A. M.				
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug 30 1917		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. UNDER 1 YEAR MONTHS DAYS YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated		BALTIMORE CITY OR COUNTY OF DEATH A.A. co				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 230 Admiral Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY A.A. Co		
13a. STATE Md			13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 230 Admiral Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver Roosevelt Creek				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Ellen Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 16 1849		17. INFORMANT ADDRESS Rev. Charles Creek 230 Admiral Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR 9 P.M. MONTH 5 DAY 7 YEAR 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 230 Admiral Dr Annapolis Md					
22a. I certify that (I) (the hospital) attended the deceased from 1935 to May 7 1979 , that (I) (we) last saw the deceased alive on MAY 1 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Ronald Pickett MD						DEGREE MD		22c. DATE SIGNED 5-8-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RON. PICKETT						22e. ADDRESS 111 Cathedral Street Annapolis, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-11-1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		23d. LOCATION CITY OR TOWN COUNTY STATE Chesterfield A.A. Md			
24. FUNERAL DIRECTOR NAME C.E. Hicks, 111 1922 Forest Drive Anna.						25a. DATE REC'D. BY REGISTRAR MAY 11 1979		25b. REGISTRAR'S SIGNATURE Henry McHenry		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10-10033



Handwritten notes and stamps, including a large 'M' stamp and various illegible markings.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-10634			
1. DECEASED NAME (TYPE OR PRINT) LEROY CRAWFORD				2a. DATE OF DEATH MONTH DAY YEAR 5 1 79				2b. HOUR 9:55 A			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 4 27 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CRAWFORD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESSIE KENT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-18-9948A		17. INFORMANT ADDRESS Annapolis, AGNES SISCOE 202 Garden Gated La. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2028 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from JAN 6 , 19 79 , to 5/1 , 19 79 , that (1) (we) lost saw the deceased alive on 5/1 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Enser W. Cole III				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENSER W. COLE III				22e. ADDRESS 121 CATHEDRAL ST. ANNAPOLIS Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-5-79		23c. NAME OF CEMETERY OR CREMATORY MOSES CEMETERY		23d. LOCATION CITY OR TOWN Drury		COUNTY 21401 STATE Maryland			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1979		25b. REGISTRAR'S SIGNATURE Pitney, Kelly			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10635

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLIS RICHARD DAFF			2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1979			2b. HOUR 8:55P _M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 01, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 65 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Mining	
13a. STATE MARYLAND				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GAMBRILLS	
14. FATHER'S NAME FIRST MIDDLE LAST Parley A. Daff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie M. Cutright		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-03-2514	
17. INFORMANT ADDRESS							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY ARREST</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) <u>CEREBROVASCULAR ACCIDENT</u> IMMEDIATE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CIRRHOSIS OF LIVER</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u> </u> 19 <u>78</u> to <u> </u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>D. J. Zimmerman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLEG ZIMMERMAN M.D.				22e. ADDRESS 425 RITCHIE HIGHWAY S.E. GLEN BURNIE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5/17/79		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.				25a. DATE PROC. BY REGISTRAR MAY 23 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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NAME	WHITE	DATE	APR 20, 1962
AGE	21	SEX	M
ADDRESS	1000 10th St, Box 100		

NAME	WHITE	DATE	APR 20, 1962
AGE	21	SEX	M
ADDRESS	1000 10th St, Box 100		

2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42, 44, 46, 48, 50, 52, 54, 56, 58, 60, 62, 64, 66, 68, 70, 72, 74, 76, 78, 80, 82, 84, 86, 88, 90, 92, 94, 96, 98, 100

8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100

1000 10th St, Box 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10636 | | DST | |
|--|--|---|--|---|--|--|---|--|--|--------------------------------|---|-----|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MYRTLE A. DEISE | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 24, 1979 | | | | | 2b. HOUR
P. M.
9:05 | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9-18-1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Charles Co. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1173 Ridge Drive - 21122 | | |
| 14. FATHER'S NAME
George Luttrell | | | | | 15. MOTHER'S MAIDEN NAME
Lydia Brown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-22-21690
220-48-7924 | | 17. INFORMANT
Mrs. Myrtle Bruscup - | | | | | ADDRESS
1173 Ridge Drive
Pasadena, Md. - 21122 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
486-
DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory arrest</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
2 week | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1-172 77 524 19 79 | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-172 77 524</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (If (we) (I) did not view the body after death, so saw the deceased alive on <u>5-24</u> 19 <u>79</u> .) | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Michael B. Pearلمان</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL B. PEARLMAN, MD. | | | | | 22e. ADDRESS
8726 Liberty Plaza
Randallstown, Maryland, 21133 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5-30-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd.-21206 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 29 1979 | | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey McCreedy</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10637
REG. NO. | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) <u>PAULINE</u> <u>DICKERSON</u> | | | | 2a. DATE OF DEATH
MONTH <u>5</u> DAY <u>22</u> YEAR <u>79</u> | | 2b. HOUR
<u>7:35</u> M | | | |
| 3 SEX
<u>F</u> | | 4 RACE
<u>B</u> | | 5 DATE OF BIRTH
MONTH <u>3</u> DAY <u>27</u> YEAR <u>13</u> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<u>66</u> YRS | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS
HOURS <u></u> MIN <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Federalsburg, Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Ann Arundale</u> MD | | | | | |
| 10 CITY OR TOWN OF DEATH
<u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Bay Manor Nursing Home</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Domestic</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Hotel</u> | | | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Caroline</u> | | 13c. CITY OR TOWN
<u>Federalsburg</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u></u> | | | |
| 14. FATHER'S NAME
FIRST <u>John</u> MIDDLE <u>Prattis</u> LAST <u></u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Ella</u> MIDDLE <u>Dickerson</u> LAST <u></u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | | | 16b. SOCIAL SECURITY NO.
<u>518-16-5238</u> | | 17 INFORMANT
ADDRESS <u>Federalsburg,</u>
<u>Charles Dickerson, 115 Davis Lane, Maryland</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u>
<u>2500</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.D. - hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u></u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>6-8-78</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u></u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u></u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u></u> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u></u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u></u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-8-78</u> to <u>5-22-79</u> , that (I) (we) lost
saw the deceased alive on <u>5-19-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Emily H. Wilson</u> | | | | DEGREE
<u>M.D.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>5-22-79</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u></u> | | | | 22e. ADDRESS
<u></u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>May 25, 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Johns Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Preston, Caroline, Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Framptom-Hawkins Funeral Home, 216 N. Main St.</u> | | | | ADDRESS
<u></u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 28 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u></u> | | | |

BP

10-10831



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10638

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rebecca Fuller Dillon
<i>Rebecca Fuller Dillon</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-2-79 | | 2b. HOUR
5A M | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
1-20-17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Annapolis General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Harry MIDDLE W. LAST Fuller | | 15. MOTHER'S MAIDEN NAME
FIRST Anita MIDDLE S. LAST Foulds | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-10-6586 | | 17. INFORMANT
Mr. R. Samuel Dillon Same as # 13 | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Squamous cell Carcinoma Throat
1490
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months |
|--|--|--|

| | | | | | |
|---|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6 3/15 79 5/2 79 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1 19 79 to 5/2 19 79, that (I) (we) lost saw the deceased alive on 5/1 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Enser W. Cole III | | DEGREE
MD | | 22c. DATE SIGNED
5/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ENSER W. COLE III | | 22e. ADDRESS
121 CATHEDRAL ST ANNAPOLIS Md. | | | |

| | | | |
|---|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
5/2/79 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore, Md. |
| 24. FUNERAL DIRECTOR
NAME
Grove Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
MAY 3 1979 | |
| ADDRESS
Hancock, Maryland | | 25b. REGISTRAR'S SIGNATURE
Fitzroy Kelcey | |

TO HOSPITAL, CLINIC, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10639

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JENNIE MARIE DISNEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 17, 1979 | | | 2b. HOUR ST
5:02 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 28, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY AA 13c. CITY OR TOWN Glen Burnie 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 13e. STREET ADDRESS 7888 Americanna Circle | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard T. Brown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Helen Stuart | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216.12.4739 | | 17. INFORMANT ADDRESS
6 S. Hollins Ferry Rd. G.B. | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular collapse
2767 DUE TO, OR AS A CONSEQUENCE OF (b) 20% Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Due to a consequence of (c) Myocardial infarction
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
3/14/79 5/17/79 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14/79 to 5/17/79 , that (I) (we) last saw the deceased alive on 5/17/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (old) physician used the body after death) | | | | | | | |
| 22b. SIGNATURE
Anastacio E. Subong | | | | DEGREE | | 22c. DATE SIGNED
5/17/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTACIO E. SUBONG, M.D., | | | | 22e. ADDRESS
1406 CRAIN HIGHWAY, #102 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 21, 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie AA Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Singleton Funeral Home, Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1979 | | 25b. REGISTRAR'S SIGNATURE
Fifty/Handy | |



Nov. 28, 1987

White

Female

X

Veryland

X

Veryland

Veryland

White

Brown

T.

Richard

218.12.479

None

None

Nov 21, 79 - Green Haven Cem.

Burial

Lincoln Memorial Home, Green Haven, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10640

| | | | | | | | |
|--|--|---|---|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| VIRGINIA | | Annie DOCKERY | | May 11, 1979 | | 0110 AM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | CAUC | FEB 25 1902 | | 77 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FORT MEADE | KIMBROUGH ARMY HOSPITAL | | Housewife | | Own Home | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| MARYLAND | | ANNE ARUNDEL | GLEN BURNIE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 2700 Finch Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| John Emmitt Pinkine | | Lillie May Hubbard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | N/A | | 202 Baylor Rd., Glen Burnie. Mr. John F. Dockery, Jr. (son) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ASCD with Atrial fibrillation</u> | | | | | | | <u>YRS.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | 5/10 79 to 5/11 79 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 79, to 5/11 79, that (I) (we) last saw the deceased alive on 5/11 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| <i>Beltran</i> | | M.D. | | 5/11/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| JUAN A. BELTRAN, M.D. | | KIMBROUGH ARMY HOSPITAL, FT. MEADE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 15 MAY 79 | | Glen Haven Mem. Pk. | | Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SINGLETON FUNERAL HOME | | GLEN BURNIE, MD | | MAY 15 1979 | | <i>Robert K. K...</i> | |

BP

100-10010

77

25-1002

U.S.A.

John F. Doherty, Jr. (son)
213-24-0478
John F. Doherty, Jr. (son)
213-24-0478
John F. Doherty, Jr. (son)
213-24-0478

John F. Doherty, Jr. (son)
213-24-0478
John F. Doherty, Jr. (son)
213-24-0478
John F. Doherty, Jr. (son)
213-24-0478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10641

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Baden DUNBAR, SR.
James Baden Dunbar | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 11 79 | | | 2b. HOUR
2 35 PM | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 10 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Genl. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Diesel Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Cottman Co. | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Douglas Dunbar | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary L. Armsready | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS Same as # 13
Mrs. Mary K. Dunbar (wife) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Ocular Melanoma</u>
1909
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>79</u> , to <u>5/11</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/11</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>W. Cole III</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
5/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. COLE III | | | | 22e. ADDRESS
121 CATHEDRAL ST. ANNAPOLIS MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
16 MAY '79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
J. Easter
SINGLETON FUNERAL HOME, GLEN BURNIE, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 15 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert McCreedy</u> | | | |

BP

18-10041

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

James E. Hagan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10642

| | | | | | |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Blanche BRADLEY | | 5-12-79 | | 11:35 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | 8-14-17 | 61 YRS | IF UNDER 24 HRS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7c. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| VIRGINIA | USA | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| ANNAPOLIS | ANNE ARUNDEL GENERAL HOSP. | | HOME MAKER | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS | | |
| MD. ANNA ARUNDEL GAMBRIILLS | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | ROUTE #301 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| JOHN R. OSBORNE | | BURLEIGH DOSS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| NO | | 220-16-5338 | NELLIE O. BAKI | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 5713 ALCOHOLIC LIVER DISEASE | | NOT KNOWN | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| NONE | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 26 1979, to MAY 12 1979, that (I) (we) last saw the deceased alive on MAY 12 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| James M Blake Jr MD | | MD | | 5/13/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| JAMES M BLAKE JR MD | | 2510 RIVA ROAD, ANNAPOLIS 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| BURIAL | | MAY 15, 1979 | OLIVET METH GEM | | CITY OR TOWN COUNTY STATE |
| | | | | | LUSBY CALVERT MD. |
| 24. FUNERAL DIRECTOR | | 25a. DATE REGISTERED | | 25b. REGISTRAR'S SIGNATURE | |
| DONALD V. BORGWARDT | | MAY 16 1979 | | Port Republic, MD. | |

10-10045

MAILED
10-10045



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10643
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN ROSS EVANS, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 10, 1979 | | | 2b. HOUR DST
6:50 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
September 22, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
43 | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Operations Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
Am. Airlines | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Barron L. Evans | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Monna G. Sloan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213 32 2894 | | 17. INFORMANT
ADDRESS
Charlotte M. Evans 807 Tranton Road Glen Burnie, Md. 21061 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Death myocardial infarction
410-
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary edema, cardiopulmonary arrest - Asphyx - Heart Failure | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> AT WORK POST WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/9/79 19 to 5/10/79 19, that (I) (we) last saw the deceased alive on 5/10/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased could not view the body after death) | | | | | | | | | | |
| 23a. SIGNATURE
Jorge B. Ramirez MD | | | | | DEGREE
MD | | 23c. DATE SIGNED
5/10/79 | | | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE B. RAMIREZ, MD | | | | | 23d. ADDRESS
325 HOSPITAL DRIVE, #207
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
May 15, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home of Brooklyn Balto., Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
21225 MAY 14 1979 | | 25b. REGISTRAR'S SIGNATURE
Patricia McCreedy | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ca-ban papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1001-2

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JAN 10 1952

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-10644
REG. NO.

E.S.T.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
AGNES IRENE FEDERLINE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 12, 1979 | | 2b. HOUR
11:10^P |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 2 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles E. Hahn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Ray | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-14-2158 | | 17. INFORMANT
ADDRESS
Joseph E. Federline Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
2500
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) SIP Myocardial Infarction x2
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetics | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-9-1979 to 5-12-1979 , that (I) (we) lost
saw the deceased alive on 5-12-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] DEGREE | | | | 22c. DATE SIGNED
5/12/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DALJIT S. SAWHNEY, M. D. | | | 22e. ADDRESS
205 BALTIMORE ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/16/79 | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marriottsville Howard Md | |
| 24. FUNERAL DIRECTOR
NAME
Witzke Funeral Home of Catonsville
1630 Edmondson Avenue Catonsville, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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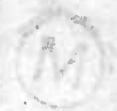
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May 22, 1978

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INDEX



STATE OF ARIZONA

USA

Arizona

NORTH RURAL HOSPITAL

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Witke Farms of Catonsville

LOUISIANA, N. D.

FOR BATTING KEMP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10645

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) <i>Lucy Hatcher</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>5-6-79</i> | | | 2b. HOUR
<i>9:20</i> M | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Cauc.</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 19 14</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>65</i> YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Annapolis MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Bay Manor Nursing Home</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>none</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>none</i> | | |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>CARROLL</i> | | 13c. CITY OR TOWN
<i>MIDDLEBURG</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>UNKNOWN</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>UNKNOWN</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | 16b. SOCIAL SECURITY NO.
<i>215-52-8349</i> | | 17. INFORMANT ADDRESS
<i>Bay Manor Nursing Home Annapolis MD</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>myocardial insufficiency old CVT</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Diabetes mellitus</i> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>5-6</i> , 19 <i>79</i> , to <i>5-6</i> , 19 <i>79</i> , that (I) (we) lost
saw the deceased alive on <i>5/5</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Emily H. Wilson</i> | | | DEGREE
<i>M.D.</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-6-79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Emily H. Wilson</i> | | | 22e. ADDRESS
<i>LITHIAN, MD. 20820</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>5-11-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Uniontown Lutheran</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Uniontown Carroll MD.</i> | | |
| 24. FUNERAL DIRECTOR
(NAME)
<i>Robert E. Brithers, 91 W. 15th St. WESTMINSTER, MD 21157</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 14 1979</i> | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Robert E. Brithers</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10646

| | | | | | | | | | |
|--|--|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Catherine NMI Fleyzor | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 10, 1979 | | | 2b. HOUR
M | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 6, 1885 | | 6 AGE (IN YEARS LAST BIRTHDAY)
94 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
Poland | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
202 Church Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Pelc | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Flis | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
220-20-6359 | | | 17 INFORMANT
Mrs. Sophie Lustica 202 Church Street Baltimore, Md. 21225 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Atherosclerosis
4409
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Senility | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 18-Apr-77 to 10-May-79 , that (I) (we) lost
saw the deceased alive on 18-Apr-77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard E. Fisher MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11-May-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard E. Fisher | | | 22e. ADDRESS
4700 Pennington Ave | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
5/14/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Anne Arundel Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McLally Funeral Home 4200 Pennington Avenue
Baltimore, Maryland 21226 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1979 | | 25b. REGISTRAR'S SIGNATURE
F. J. Kelly | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10647

| | | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DOROTHY M. FREBURGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 30 79 | | | 2b. HOUR
M
12 NOON | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 17 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
63 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Riviera Bch | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
187 Hilltop Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Greene | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215 01 2194 | | 17. INFORMANT
ADDRESS
Pasadena, Md.
Thomas E. Freburger 8532 Main Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) Ce Brest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25 , 19____, to 5/30/79 , 19____, that (I) (we) lost
saw the deceased alive on 5/30/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/31/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. P. WATKINS | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6/2/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A A Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce, 4001 Ritchie Hg., Baltimore | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 5 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

100-10001



[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| | | | | | |
|--|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY ANN GALLAGHER | | 2a. DATE OF DEATH
MONTH 5 DAY 30 YEAR 1979 | | 2b. HOUR
A M | |
| 3. SEX
F | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 4 DAY 21 YEAR 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
928 WELLS AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOME | | 12b. KIND OF BUSINESS OR INDUSTRY
HOUSEWIFE |
| 13a. STATE
MD. | | 13b. COUNTY
AA | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST EPHRAIM MIDDLE HARRIS LAST HARRIS | | 15. MOTHER'S MAIDEN NAME
FIRST JOHN MIDDLE GALLAGHER LAST #13 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
214620851 | | 17. INFORMANT
JOHN GALLAGHER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral anoxia.
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis.
DUE TO, OR AS A CONSEQUENCE OF (c) ysr. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 25 OCT 1977 to 30 May 1979 , that (I) (we) saw the deceased alive on 30 May 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Cecilian H. Choate, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
31 May 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM H. CHOATE | | 22e. ADDRESS
WEST ST. ANNAPOLIS, MD. | | 22f. MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
6/2/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARYS | |
| 23d. LOCATION
CITY OR TOWN
ANNAPOLIS | | 23e. COUNTY
AA | | 23f. STATE
MD | |
| 24. FUNERAL DIRECTOR
John M. G. L. L. L. | | ADDRESS
Chesapeake, md. | | 25a. DATE RECEIVED BY REGISTRAR
JUN 1 1979 | |
| 25b. REGISTRAR'S SIGNATURE
John M. G. L. L. L. | | 25c. REGISTRAR'S NAME
John M. G. L. L. L. | | | |

BP

10-10018

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10649

| | | | | | |
|--|---|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Orpha Margaret Georg | | | 2 DATE OF DEATH MONTH DAY YEAR HOUR
51 11 79 8P M | | |
| 3 SEX
7 | 4 RACE
W | 5 DATE OF BIRTH
MONTH DAY YEAR
1-22-00 | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
AACo MD. | | |
| 10 CITY OR TOWN OF DEATH
Brooklyn | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hammond Lane Nursing Home | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Md | 13b COUNTY
AACo | 13c CITY OR TOWN
Brooklyn | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS
Hammond Lane | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
George Krause | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Opel | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO.
214343439 | 17 INFORMANT ADDRESS
Robert D. George, Severn, Md | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Progressive Coma</u>
3314
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Hydrocephalus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCVD</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>78</u> , to <u>May 1</u> , 19 <u>79</u> , that (I) was last saw the deceased alive on <u>March 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>William</u> | | | | 22c DATE SIGNED
S-1-79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Deeni Tason | | | | 22e ADDRESS
Hammond Lane Medical Center | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
5-4-79 | 23c NAME OF CEMETERY OR CREMATORY
Glen Haven | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie AAcO Md |
| 24 FUNERAL DIRECTOR
NAME
Alexandros F.H. | | 24b ADDRESS
12 Ridge Ave, Annapolis Md | | 25a DATE REC'D. BY REGISTRAR
MAY 2 1979 | |
| 25b REGISTRAR'S SIGNATURE
<u>Henry McCreedy</u> | | | | | |

BP

78-10042

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



NOV 1978

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VIR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10650

| | | | | | |
|---|--|--|---|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| Beverly Marie Giehm | | 5-30-1979 | | 6:15A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Female | White | 7-24-1931 | 47 YRS. | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 9c. MARRIED | | 9d. BALTIMORE CITY OR COUNTY OF DEATH | |
| Wyoming | USA | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Anna Arundel Co. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Shady Side | 1312 Spruce St. | US Army Ret. | | US Gov. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | AACo. | Shady Side | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1312 Spruce St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| Rudolf Carl Giehm | | | Marion Kathleen Cranston | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | 1950-1970 | | Edith Bancroft Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Lymphoma | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| F. Linhardt | | M.D. Deputy | | 5/31/79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| F. Linhardt | | Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | COUNTY | STATE |
| Cremation | 5-31-79 | Cedar Hill Crematory | Suitland | PG | Md. |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JUN 1 1979 | | L. K. Crady | |
| Hardesty Funeral Home | | Annapolis Md. | | | |

02801-01

19
(M)

END



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10651

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| THOMAS HENRY Glenn | | MAY 8, 1979 | | 74 ³ PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | Negro | Nov 17 1904 | 74 YRS. | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Anne Arundel | USA | | Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SEVERNA PARK | 31-White Rd | | Contract Labor | | Contracting |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Anne Arundel | Severna Park | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 31-White Rd |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Johnston (N) Glenn | | MARY Jennings | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 220-07-8691 | MARTHA Glenn 31-White Rd. Severna Park MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL Infarction | | | | | 10 min |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC Cardiovascular disease | | | | | 9 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Myocardial infarction 13-Sep-1973 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 17, 19 69, to May 8, 19 79, that (I) (we) last saw the deceased alive on April 23, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| T.C. Cullis MD | | | | 8 MAY 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| T.C. Cullis MD | | 7-Riggs Ave Severna Park Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| BURIAL | | 5-12-79 | ASBURY TOWN NECK CEME. | | Severna Park Maryland |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WILLIAM REESE & SONS MORTUARY, P.A. | | MAY 11 1979 | | [Signature] | |

12001-0



MAY 11 1963
MAY 11 1963
MAY 11 1963

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10652 S.T.

| | | | | | | | | | |
|---|--|--------------------------|--|---|--------------------------------------|-------|-----------------|------|--------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| NORMA | | (nmn) | | GOCHNAUER | MAY 30, 1979 | | | | 4:05A _M |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| Female | White | | June 23, 1891 | | 87 | | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | | ANNE ARUNDEL COUNTY MD | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Homemaker | | Own Home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | |
| Maryland | A.A. | Millersville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 310 Moncton Court | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | |
| William | | Ella | | no | | | | | |
| 17. INFORMANT | | 18. SOCIAL SECURITY NO. | | 19. ADDRESS | | | | | |
| Mrs. Lynda A. Staples (grand daughter) | | 225070148D | | Sames as #13 | | | | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardioparic shock</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI & advanced ASCVD, A fib</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF - DDD</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>410-</u> | | | | | | | | | |
| 21a. DATE OF OPERATION | | | | | | | | | |
| 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21g. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Signs may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

78-10052-2

| | | | | |
|-------------|-------------------|----------------|----------------|--------------|
| NO. 10052-2 | DATE MAY 30, 1978 | NAME GOSCHAUER | TIME 1:00 P.M. | ROOM 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |
| 10052-2 | 10052-2 | 10052-2 | 10052-2 | 10052-2 |

RECEIVED
MAY 30 1978
FBI - BALTIMORE
MAY 30 1978
FBI - BALTIMORE

RECEIVED
MAY 30 1978
FBI - BALTIMORE
MAY 30 1978
FBI - BALTIMORE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10653

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SLAVKO GOSHEFF

2a. DATE OF DEATH MONTH DAY YEAR
5/25/79 2b. HOUR
1:19 PM

3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
8-5-1894

6. AGE (IN YEARS LAST BIRTHDAY) 84 7. UNDER 1 YEAR MONTHS 8. UNDER 24 HRS. DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Yugoslavia 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD.

10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker 12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.

13a. STATE Md. 13b. COUNTY AACo. 13c. CITY OR TOWN Gumballs 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS
2325 Patuxent River Rd.

14. FATHER'S NAME FIRST MIDDLE LAST
Goshe UNK

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Morie UNK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 218-42-6462 17. INFORMANT ADDRESS
Richard Gosheff Same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CVA**
DUE TO, OR AS A CONSEQUENCE OF (b) **COPD**
DUE TO, OR AS A CONSEQUENCE OF (c)

CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
PM 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **1972**, 19____, to **1979**, 19____, that (I) (we) last saw the deceased alive on **3/79**, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE **S. P. Watkins** DEGREE ATTENDING ☒ MEDICAL ☐ STAFF ☐ PHYSICIAN ☐ DIRECTOR ☐ PHYSICIAN ☐ 22c. DATE SIGNED
5/25/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **S. P. WATKINS** 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 5-28-79 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis AACo. Md.

24. FUNERAL DIRECTOR Hardesty Funeral Home ADDRESS Annapolis, Md. 25a. DATE REC'D. BY REGISTRAR MAY 29 1979 25b. REGISTRAR'S SIGNATURE **Henry A. Brady**

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10023

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250



Private

Private

Private

PTER & YAMI

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10654

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|--|--|--------------------------------------|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2e. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2f. HOUR | |
| John Edward Gott, Jr. | | John | | Edward | | Gott, Jr. | | 5 30 1979 | | 5 | | 30 | | 1979 | | 0 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| M | W | June 26 1916 | | 62 YRS. | | | | | | 5 30 1979 | | 5 | | 30 | | 1979 P.M. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | A.A. Co | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Glen Burnie | | North Arundel Hospital | | Plumber | | Plumbing Co. | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Anne Arundel | | Pasadena | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt. 14, Box 53-A, 21122 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| John Edward Gott, Sr. | | Nora (Unknown) | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 212-16-3946 | | Charles Gott/623 209th St/Pasadena | | 21122 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| 4149 | | Coronary Artery Disease | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | DATE
SIGNED | | 5/30/79 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| E. Linhardt | | 21223 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 06/02/79 | | Crest Lawn Gardens | | Howard County, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Walters Funeral Home/Pratt & Stricker Streets | | 21223 | | JUN 4 1979 | | Hickey/Roby | | | | | | | | | | | |

100-10024

100-10024



TO HOSPITAL SURGEON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-10655 | | | |
|---|--|---|--|--|--|--|--|---|--|--|--------|--|-------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY | | MIDDLE D. CONNELLY | | LAST GOTTIEB | | 2a. DATE OF DEATH | | MONTH 5 | DAY 19 | YEAR 79 | 2b. HOUR 11:45 AM |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH | | MONTH 12 | | DAY 12 | | YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN | | 12b. KIND OF BUSINESS OR INDUSTRY Public Schools | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13a. STREET ADDRESS 115 Conduit Street | | 13b. CITY OR TOWN | | 13c. STATE | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-26-2830 | | 17. INFORMANT Terry C. Whiting | | 17a. ADDRESS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Encephalitis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 hrs | | | |
| 5733 DUE TO, OR AS A CONSEQUENCE OF (b) Edipathic Hepatitis | | | | | | | | | | 27 min | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-19-79 to 5-19-79, that (I) (we) last saw the deceased alive on 5-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Frank M. Shipley M.D. | | | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-20-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.M. SHIPLEY | | | | | | | | 22e. ADDRESS Annapolis | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 5/21/79 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN Suitland P.O. | | COUNTY MD. | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons | | | | | | | | ADDRESS Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

10822-8

4

MAILED

BP

DHMH - 16 50M.7/77
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-10656 |
|---|--|---|--|---|---|---|--|--|--|-------------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Joseph James Greenlaw</u> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>5/16/79</u> | | | 2b. HOUR
<u>1:35</u> AM | | |
| 3. SEX
<u>M</u> | | 4. RACE
<u>W</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>6-7-1897</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>81</u> YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Titusville Penna USA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Anne Arundel Co.</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Anne Arundel General Hosp.</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Physician</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<u>Md.</u> | | 13b. COUNTY
<u>A.A. Co.</u> | | 13c. CITY OR TOWN
<u>Shady Side</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<u>4913 Hine Dr.</u> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Frederick Greenlaw</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Mary McCaffrey</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>no</u> | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
<u>no</u> | | 17. INFORMANT
<u>Helen Greenlaw</u> | | ADDRESS
<u>same as 13 e.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4280 Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 mo</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>11 15 19 79</u> P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>MAY 15 19 79</u> , to <u>MAY 16 19 79</u> , that (I) (we) last saw the deceased alive on <u>MAY 15 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harvey J. Steinberg</u> | | | | | DEGREE
<u>MD.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/16/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HARVEY J STEINBERG</u> | | | | | 22e. ADDRESS
<u>SHADYSIDE RD 20867</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>5/18/79</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Pt Lincoln Mausoleum</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Brentwood Md.</u> | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hardesty Funeral Home</u> | | | | | ADDRESS
<u>12 Ridgely Ave. Ann. Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 16 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Petry Helms</u> | |

MEDICAL CERTIFICATION



18-10050

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

Joseph W. ...
Gardner ...
...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10657 DST

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE H. GRIFFIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 7, 1979 | | 2b. HOUR P.
8:40 M. |
| 3 SEX
female | 4 RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
May 17, 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD | |
| 10 CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Hobbs | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Hamilton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 36 5144 | | 17 INFORMANT ADDRESS
Paul J. Griffin (same as 13e) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Carcinomatous
1990
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mo |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Sergio Alvarez | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SERGIO ALVAREZ, MD. | | 22e. ADDRESS
300 Hospital Drive, #134
Glen Burnie, Md., 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5/11/79 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | ADDRESS
4001 Ritchie Hg., Balto. | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



•

9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

North Atlantic Treaty

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300 - Total Paid - 1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10658

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ETHEL D HARDESTY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 13 79 | | | 2b. HOUR
7:40 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 15 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mt Harmony Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
----- | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
3685 Clydesdale Rd. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles A.F. Cox | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eliza Catterton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
Gilbert J. Hardesty | | ADDRESS
3710 Clydesdale Rd.
Edgewater Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cachexia of malignancy.
1509
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastasis.
DUE TO, OR AS A CONSEQUENCE OF
(c) Esophageal Carcinoma.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
Congestive heart failure, Chronic atelectasis. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/79, 1979, to 5/13/79, 1979, that (I) (we) last saw the deceased alive on 5/13/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Guy Chaurman | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE, SIGNED
5/13/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Davidsonville Methodist | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Davidsonville Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
12 Ridgely Ave.
Ann. Md. | | 25b. REGISTRAR'S SIGNATURE
MAY 16 1979 | |

82301-03

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10659 | |
|---|--|---|--------|--|--|---|----------------------------|--|--------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| JAMES ALBERT HARE | | | | 5 24 79 | | 10:30 | | | | M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | WHITE | | APRIL 11, 1920 | | 59 | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | ANNE ARUNDEL | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | DRAPERY-INSTALLER | | STEWART | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1717 SAUNDERS WAY | | | |
| MARYLAND | | ANNE ARUNDEL | | GLEN BURNIE | | | | | | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| UNKNOWN | | | | | UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS SAME AS # 13 | | |
| NO | | | | | N/A | | 220.07.4186 | | MRS. ALDA V. HARE (WIFE) | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | | |
| 410- DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart Disease 5 yrs | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| Congestive heart Failure, Hypertension | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 4, 1978, to Aug 24, 1979, that (I) (we) lost saw the deceased alive on Aug 7, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | | | |
| Joseph Taler, M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | Aug 25, 1979 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| JOSEPH TALER | | | | | 95 AQUARHART RD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | | |
| BURIAL | | 29 MAY '79 | | CEDAR HILL CEMETERY | | BROOKLYN A.A. | | MD. | | | |
| 24 FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME SINGLETON FUNERAL HOME, Glen Burnie, MD | | | | | MAY 28 1979 | | [Signature] | | | | |

BP



10883

2 24 70 10:10

JAMES ALBERT WARE

ALL

GLENN BURNIE NORTH BRUNDEL HOSPITAL

ANNIE BRUNDEL

270.07.418 (Mrs. J. W. Ware (Wife))

JOSEPH TALEP

25 AQUARIAN RD



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10660

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---------------------|--|--------------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| | | FIRST MIDDLE LAST
Myrtha Digne HENDERSON | | 5 | | 130 | | 179 | | 210 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | |
| Female | | Caucasian | | MONTH DAY YEAR
Dec 15 1942 | | 36 YRS | | MONTHS DAYS | | HOURS MIN | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | U.S.A. | | | | Anne Arundel Co MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Annapolis | | Anne Arundel General | | Computer Tech. | | Computer | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Anne Arundel | | Riviera Beach | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8456 Greenway, Rd. | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST
George Henry Lutsche Jr. | | FIRST MIDDLE LAST
Myrtha A. Yewell | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 220-38-9430 | | Donald E. Henderson | | same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Metastatic Melanoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 1729 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 5:30 to 5:30 1979, and that (2) (we) last saw the deceased alive and above (1) (we) did not see the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| Dr. Arnold G. Alexander | | Attending Physician | | 5-31-79 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| Dr. Arnold G. Alexander | | Anne Arundel Gen. Hosp. Annapolis, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 6/2/1979 | | Glen Haven Mem. Park | | Glen Burnie Anne Arundel Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| McCully F. H. Mountain & Tick Neck Rds. Pas. Md. | | 21142 | | JUN 1 1979 | | Hickey McCreedy | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10661

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|---------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Linda D. Henry</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>5/31/79</i> | | 2b. HOUR
DAY MONTH
<i>2:29A</i> | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10-16-41</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS HRS MIN
<i>37</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Penna.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel Co.</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis,</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Anne Arundel Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Employee-A.A. County</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Anne Arundel</i> | | 13c. CITY OR TOWN
<i>Crownsville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
<i>1581 Crownsville, Rd.</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Emmor Worth</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Hilda Hiddleston</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
<i>n/a</i> | | 17. INFORMANT
ADDRESS
<i>Darrell L. Henry Same 13a-e</i> | | | |

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>pneumonia</i>
<i>431-</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>intracerebral hemorrhage</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>acute + chronic alcoholic liver disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i>
<i>2 1/2 weeks</i>
<i>years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>4/17/79</i> 19 <i>79</i> to <i>5/31/79</i> 19 <i>79</i> , that (1) (we) lost
saw the deceased alive on <i>5/30/79</i> 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Wm A Cassidy</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>5/31/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Wm A Cassidy</i> | | 22e. ADDRESS
<i>2510 Riva Rd #325 Annapolis MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>June 1, 1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Metropolitan Crematory Alexandria, Va.</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Annapolis MD</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Deall Funeral Home, 1212 West St., Annp. Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JUN 4 1979</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreedy</i> | | | |

BP

10001-0



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10662

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--------------------------------------|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE OF DEATH | | | 2d. DATE OF DEATH | | |
| PAUL A. HILEMAN | | | MONTH DAY YEAR | | | MONTH DAY YEAR | | | MONTH DAY YEAR | | | MONTH DAY YEAR | | |
| 3. SEX
male | | | 4. RACE
white | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | 7. IF UNDER 1 YR | | |
| 3 MONTH DAY YEAR | | | 3 MONTH DAY YEAR | | | 3 MONTH DAY YEAR | | | 3 MONTH DAY YEAR | | | 3 MONTH DAY YEAR | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | |
| West Va. | | | U.S.A. | | | WIDOWED | | | Anne Arundel County | | | Glen Burnie | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. INSIDE CITY LIMITS? | | |
| Glen Burnie | | | 228 Margate Drive | | | Laborer | | | | | | YES NO | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. STREET ADDRESS | | | 13e. STREET ADDRESS | | |
| Md. | | | Anne Arundel | | | Glen Burnie | | | 228 Margate Dr. | | | 228 Margate Dr. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Paul | | | Wanita | | | No | | | Unknown | | | Wanita Hileman | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | YES NO | | | 21b. TIME OF INJURY | | |
| 9530 IMMEDIATE CAUSE (a) Asphyxia | | | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | P.M. 5/2 1979 | | |
| (b) hanging | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | hanged self | | |
| (c) | | | | | | | | | | | | 21d. INJURY OCCURRED | | |
| | | | | | | | | | | | | WHILE NOT WHILE AT WORK | | |
| | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | |
| | | | | | | | | | | | | home | | |
| | | | | | | | | | | | | 21f. LOCATION | | |
| | | | | | | | | | | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | | | | | 228 Margate Dr. Glen Burnie, Maryland | | |
| 22a. I certify that I took charge of the remains described above, held on | | | 22b. DATE | | | 22c. NAME OF CEMETERY OR CREMATORY | | | 22d. LOCATION | | | 22e. DATE | | |
| Autopsy Inspection Inquiry and in my opinion | | | 5/7/79 | | | Greenmount Cem. | | | Baltimore | | | MAY 14 1979 | | |
| death resulted from Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | 22f. DATE | | |
| Actual Signature | | | Ann M. Dixon, M.D. | | | 111 Penn Street | | | 22g. DATE | | | 22h. DATE | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 22i. DATE | | | 22j. DATE | | | 22k. DATE | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | 23e. DATE | | |
| Cremation | | | 5/7/79 | | | Greenmount Cem. | | | Baltimore | | | 23f. DATE | | |
| 24. FUNERAL DIRECTOR | | | 24b. DATE | | | 24c. NAME OF CEMETERY OR CREMATORY | | | 24d. LOCATION | | | 24e. DATE | | |
| B. Dabrowski & Son | | | 2818 E. Baltimore St. | | | | | | | | | 24f. DATE | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10663

| | | | | | |
|--|---|---|---|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HANFORD E. HINKEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 18 79
2b. HOUR
6 ¹⁵ P. M. | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
03 14 12 | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
OHIO | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL CO. MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOHIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR LAST OF WORKING LIFE)
YACHT BROKER | | 12b. KIND OF BUSINESS OR INDUSTRY
MARINA |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD. | 13b. COUNTY
AA | 13c. CITY OR TOWN
ANNAPOHIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
519 Royal St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANKLIN M. HINKEL | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATHERINE HOFFENBERGER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | 17. INFORMANT
ADDRESS
CELINE E. HINKEL #13 | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>—</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. — 19 79 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>79</u> , to <u>18 May</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>6:00 pm</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>N. A. Capozzoli</u> | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/18/79</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Nicholas Capozzoli</u> | 22e. ADDRESS
<u>25 Shaw St. Annapolis Md.</u> | | |

| | | | |
|--|---|--|---|
| 23. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23a. DATE
<u>5/22/79</u> | 23b. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln</u> | 23c. LOCATION
CITY OR TOWN COUNTY STATE
<u>Brentwood P.G. Md.</u> |
| 24. FUNERAL DIRECTOR
NAME
<u>John M. Lytle & Son Annapolis Md.</u> | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 24 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCreedy</u> |

10001-8

(M)

August 1951

210 Royal St.

to the

#13

See page 10

See page 10

See page 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10664

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HAROLD | | FIRST
H | | MIDDLE
O | | LAST
LAND | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/1/79 | | 2b. HOUR
5:35 P.M. | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 15 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
SHADYSIDE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1338 Scott Town Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BLAKE M. HOLLAND | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RUTH ADAMS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
SHIRLEY A. HOLLAND | | ADDRESS
1338 Scott Town Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiogenemous failure
5770
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial infarction + stroke lung
DUE TO, OR AS A CONSEQUENCE OF
(c) acute pancreatitis | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 wks. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
diabetes hypertension epigenomoholity | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 5/2/79 , 19 79 , to 5/1/79 , 19 79 , that (ii) (we) last saw the deceased alive on 5/1/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Wm A Cassidy | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/4/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm A Cassidy | | 22e. ADDRESS
2510 Riva Rd Annapolis 21401 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-5-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLLAND CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Churchton Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | ADDRESS
Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1979 | | 25b. REGISTRAR'S SIGNATURE
Richard McCreedy | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DST

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELSIE E. HOUCK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 25, 1979 | | | 2b. HOUR
P. M.
8:30 P. | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 22 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
65 YRS | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN.
00 00 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LINE WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY
GENERAL ELE- | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
PASADENA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
705 Holly Avenue, 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN DAY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTHA FISCHER | | | 16. ADDRESS
PASADENA, MD. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
NO | | | 16b. SOCIAL SECURITY NO.
217-18-6104 | | 17. INFORMANT
EDWARD J. HOUCK, 705 HOLLY AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe Dehydration
496-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lung Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
years
years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25 , 19 79 , to 5-25 , 19 79 , that (I) (we) last saw the deceased alive on 5-25 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Sang C. Doh | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-26-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sang C. Doh, MD | | | 22e. ADDRESS
95 Aquahart Road
Glen Burnie, Maryland, 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
05-30-79 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC., | | | ADDRESS
4107 WILKENS AVE. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP

100-10000

CONTINUED FROM PAGE 1



Handwritten signature or initials.

100-10000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DPHM - 17
(VR A15ME5)
15M 7/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-10666 | |
|--|---------------------|--|---|---|-----------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MATTIE Sheppard Hutson | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 29 1979 | | 2b. HOUR P | | | |
| 3 SEX Female | 4 RACE white | 5. DATE OF BIRTH
MONTH DAY YEAR Oct. 2, 1893 | 6. AGE (IN YEARS)
LAST BIRTHDAY 85 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 5 29 1979 | | 7d. HOUR P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A. Aco. | | | | | |
| 10. CITY OR TOWN OF DEATH Arnold | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 Carlisle-DK. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY AnneArundel | | 13c. CITY OR TOWN Arnold | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 700 Carlisle Drive 21012 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST William R. Rayne | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Martha Purnell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 21 3209566 | | 17. INFORMANT (daughter-in-law) same as #13
Mrs. Brightsie W. Hutson | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis - D.V.B.
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE E. L. Howard | | | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER Depot 9 | | DATE SIGNED 5/29/79 | |
| EXAMINER'S NAME (TYPE OR PRINT) E. L. Howard | | | | ADDRESS Annapolis, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE June 1, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Pk. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Berlin Worcester Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Singleton ADDRESS Funeral Home, Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 31 1979 | | 25b. REGISTRAR'S SIGNATURE Ernest H. Hardy | | | | | |



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Martin and 2nd

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M. K. C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **79-10667**

| | | | | | | | |
|--|--|--|---|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR DST | |
| | | WILLIAM A. JACKSON | | MAY 22, 1979 | | 11:05A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | Black | 12 3 1892 | | 86 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | USA | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Construtinn Retired | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| Md | AA Co | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Box 309 Solley Road | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Edward Jackson | | Georgianna Boothe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | |
| No | | 217 16 1615 | | Lillian Scurry Box 493E Magothy Beach Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Chronic Renal Failure -</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>HSVH D - CHF</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chole cystitis - Chole lithiasis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 10</u> 19 <u>79</u> , to <u>May 22</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>May 21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| BENITO MARTINEZ, M.D. | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| | | 2932-A MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 5-26-79 | | Halls Church Yard | | Glen Burnie A.A. CO. Md. | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | |
| Isaiah L. Brown & Son PA 1913 W. Baltimore | | | | St. | | MAY 25 1979 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-11881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP _____

DHMM - 16 50M 7/77
(VR A 15 (4))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10668

| | | | | | |
|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
LOUISE LULA JOHNSON | | MONTH DAY YEAR
5/29/79 | | 655 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | NEGRO | MONTH DAY YEAR
MAY 1 1895 | | 84 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD | U.S.A. | | | A.A. CO MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| ANNAPOLIS | A.A. GENERAL | | HOUSEWIFE | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | B.A. | LOTHIAN | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1229 WRIGHTSON RD | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| LEMMUEL UNK CHASE | | ISA KELLE JONES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 217-56-4317 | | Mrs. RUTH J. COLLINS 1229 WRIGHTSON RD | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PROBABLE CANCER OF OVARY
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 MO |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from MAY 1976, to MAY 29, 1979, that (I) (we) saw the deceased alive on 5/29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| HARVEY J. STEINFELD | | M.D. | | 5/31/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| HARVEY J. STEINFELD | | SHAYSIDE MD 20867 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | JUNE 2-1979 | MOSES | | LOTHIAN A.A. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| C.E. HICKS 1922 Forest Drive ANNAPOLIS | | JUN 5 1979 | | Ruth J. Collins | |

00001-0

2/24/66

Large Lul A Johnson

Franklin V. Smith 1 mile

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

1.5 A 1.5 A 1.5 A

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10669

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Willie G. Johnson | | 2a. DATE OF DEATH MONTH DAY YEAR
5-25-79 | | 2b. HOUR
8:05 AM | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
9-6-06 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bay Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Patterson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
— — — | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
— — — | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
496-24-90263 | |
| 17. INFORMANT | | ADDRESS | | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>uremia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>a SUR with severity</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | |
|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>79</u> , to <u>5-25</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
Emily H. Ur lim, M.D. | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22c. DATE SIGNED | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Emily H. Ur lim M.D. |
| 22e. ADDRESS
Bay Manor Md. | |

| | | | |
|---|--|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5/31/79 | 23c. NAME OF CEMETERY OR CREMATORY
Richmond's Mausoleum | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME
Evelyn D. Dashiell | ADDRESS
P.O. Box 606 E. Baltimore Md. | 25a. DATE REC'D. BY REGISTRAR
MAY 29 1979 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

00001-01



[Faint, mostly illegible handwritten text across the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10670

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Elizabeth S. Jones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 31 79 | | 2b. HOUR
2:10 PM | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
9 6 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
HUNNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS
AHLGREN Hospt. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MD. | 13b. COUNTY
AA | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
992 St. Margarets Dr. | | |
| 14. FATHER'S NAME
M'LEAN | | 15. MOTHER'S MAIDEN NAME
BESSIE | | 16. ADDRESS
WELCH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT
ARTHUR JONES #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Lung Cancer
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from March 3, 19 79, to _____, 19 _____, that (1) (we) lost saw the deceased alive on 5/30, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Enser W. Cox III | | DEGREE
MD | | 22c. DATE SIGNED
5/31/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ENSER W. COX III | | 22e. ADDRESS
121 CATHEDRAL ST ANNAPOLIS Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(IF CRT)
Burial | | 23b. DATE
6/3/79 | | 23c. NAME OF CEMETERY OR CREMATORY
DAVIDSONVILLE METH | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
DAVIDSONVILLE AA MD | | 23e. DATE REC'D. BY REGISTRAR
JUN 1 1979 | | 23f. REGISTRAR'S SIGNATURE
Hofrey McCreedy | | |

100-10010

RECEIVED
FEB 22 1964
U.S. DEPARTMENT OF JUSTICE

RECEIVED
FEB 22 1964
U.S. DEPARTMENT OF JUSTICE



TO THE
HONORABLE
J. EDGAR HOOVER
DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
FROM
JAMES EARL RAY
MEMPHIS, TENNESSEE
RE
MURDER OF MARTIN LUTHER KING, JR.
4/4/68
Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. One copy of the same is being furnished to the Memphis Office for its information.
Very truly yours,
JAMES EARL RAY
Special Agent in Charge
Memphis Office

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10671 D.S.T.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN AUGUSTA JONES | | 1a. DATE OF DEATH
MONTH DAY YEAR
5/20/79 | | 2b. HOUR
3 07 A.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 18, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Reading, Penna | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Private Duty | | | |
| 13a. STATE
Md | | 13b. COUNTY
AACo | | 13c. CITY OR TOWN
Crownsville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Phillip William Kolbe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Rebecca Schaeffer | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
213 74 3925 | | 17. INFORMANT
ADDRESS
E. Francis Jones, Crownsville, Md. 21032 | |
| 18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent myocardial infarction
410-
DUE TO, OR AS A CONSEQUENCE OF (b): with pericarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (c): of Cardiac muscle atrophy
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Coronary Stenosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20/79 to 5/20/79 , that (I) (we) last saw the deceased alive on 5/20/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Anastacio E. Subong | | DEGREE | | 22c. DATE SIGNED
5/25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTACIO E. SUBONG M.D. | | 22e. ADDRESS
MEDIX BLDG SUITE 102
1406 CRAIN HWY., GLEN BURNIE, MD 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-23-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Baldwin Memorial | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Millersville AACo Md | | 23e. DATE REC'D. BY REGISTRAR
MAY 21 1979 | | 23f. REGISTRAR'S SIGNATURE
Patricia McHenry | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401 | | | | | |

BP

15201-2



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10672

REG. NO.

FOR
 1. STATE
 REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JESSE JOSEPH JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 22, 1979 | | 2b. HOUR DST
11:20A |
| 3. SEX
Mal | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 2 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Crownsville | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
Box 891 Crownsville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jennie M. Hargett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
A-061-348 | | 17. INFORMANT ADDRESS
Edna M. Meyers same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multifactorial Carcinoma
1539
DUE TO, OR AS A CONSEQUENCE OF (b) Ca Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
CNF APTD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22/79 19 to 5/22/79 19, that (I) (we) last saw the deceased alive on 5/22/79 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I saw) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jorge B. Ramirez | | DEGREE
MD | | 22c. DATE SIGNED
5/22/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE B. RAMIREZ, M.D. | | 22e. ADDRESS
325 HOSPITAL DRIVE
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 23e. DATE REC'D. BY REGISTRAR
MAY 25 1979 | | 23f. REGISTRAR'S SIGNATURE
[Signature] | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George J. Gonce 4001 Ritchie Hwy Balto 21225 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

19-10075



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10673

| | | | | | | | | | | | |
|--|--|--|---|---|--------------------------------|--|--|--|------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL H. Kellam | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 12 79 | | | 2b. HOUR
5 50 PM | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 30 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
26 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tile Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Shadyside | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Snug Harbor | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alphus D. Kellam | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Getsy Orrell | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
577-10-3840 | |
| 17. INFORMANT
P.O. Box 41
Gaylord H. Kellam, St. Leonards, Md. | | | | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gram negative septicemia
 1550
 DUE TO, OR AS A CONSEQUENCE OF (b) Meningitis
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
 DUE TO, OR AS A CONSEQUENCE OF (c) Hepatitis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4124 79 512 79 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above the deceased alive on 5/12/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | 22c. DATE SIGNED
5/12/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | | | 22e. ADDRESS
1616 Forest Drive Annapolis, MD | | | |

| | | | | | | | |
|---|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
05-18-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenhill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Greensboro North Carolina | |
| 24. FUNERAL DIRECTOR
NAME
Beall Funeral Home, 1212 West St., Anna., Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 16 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

81301-01

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-10674
REG. NO.

E.D.T.

| | | | | | | |
|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM STEPHAN KRAUSMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 1, 1979 | | 2b. HOUR
1:50 A M | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
March 12, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
B&O Railroad | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1514 Eastway 21061 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nicodemous Krausman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
705-07-6510 | | 17. INFORMANT
Mrs. Eunice F. Krausman | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Bladder
1889
DUE TO, OR AS A CONSEQUENCE OF (b) with metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.) | | | | | | |
| 22b. SIGNATURE
<i>Theodore Osius</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THEODORE OSIUS, M.D. | | | | 22e. ADDRESS
325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
5/2/79 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MacNabb Funeral Home Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 3 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

78-10874

7-7-7

1950

MAY 19 1950

MAY 19 1950

MAY 19 1950

MAY 19 1950

SHARPE COUNTY

SHARPE COUNTY

SHARPE COUNTY

SHARPE COUNTY


 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

 79-10675
REG. NO.

| | | | | | | | |
|---|--|---|--|--|--------------------------|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BERTHA A. KROGMAN | | | 2a DATE OF DEATH
MONTH DAY YEAR
5 15 79 | | 2b HOUR
9 A.M. | | |
| 3 SEX
FEMALE | | 4 RACE
CAUC. | | 5 DATE OF BIRTH
MONTH DAY YEAR
1 18 92 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co., MD. | |
| 10 CITY OR TOWN OF DEATH
Milkersville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Knollwood MANOR | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
WAITRESS | | 12b KIND OF BUSINESS OR INDUSTRY
MILK BAR | |
| 13a STATE
Md. | | 13b COUNTY
A.A. | | 13c CITY OR TOWN
linthicum | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
PATRICK TIGHE | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA BLIDEN | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b SOCIAL SECURITY NO
214-26-8755 | | 17 INFORMANT ADDRESS
LOUIS R. KROGMAN, 108 S. LONGCROSS ROAD | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Senile Dementia. | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec 12 , 19 78 , to May 15 , 19 79 that (I) (we) last saw the deceased alive on May 14 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Paul S Rhodes MD | | | | DEGREE
MD | | 22c DATE SIGNED
5/15/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Paul S RHODES MD | | | | 22e ADDRESS
1667 Crofton Center Crofton. | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
05-18-79 | | 23c NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE. | | | | 25a DATE REC'D. BY REGISTRAR
MAY 16 1979 | | 25b REGISTRAR'S SIGNATURE
Barry McCreedy | |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

25001-05



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10676

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Walter V KROMAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 1, 1979 | | 2b. HOUR
12:30AM | | | | | | |
| 3 SEX
Male | | 4 RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 10, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel | | | MD | | |
| 10 CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RESTAURANT | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Ret. | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3661 Second Avenue | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
EVANDER KROMAS | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADAHIDE HAWKINS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
578-38-1047 | | |
| 17 INFORMANT
MAEIE P. KROMAS | | | ADDRESS
13 | | | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4/40 | | | (b) Coronary atherosclerosis | | | chronic | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic pulmonary fibrosis & respiratory insufficiency | | | | | | | | | | | |
| 19a. DATE OF OPERATION
Not applicable | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from xxxxxx January 18, 1979 , to May 1, 1979 , that (I) (we) saw the deceased alive on xxxxxx above, (I) (we) (did) xxxxxx view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Charles W. Kinzer | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
May 1, 1979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles W. Kinzer, M. D. | | | 22e. ADDRESS
16 Murray Ave. Annapolis, MD 21401 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
5/3/79 | | 23c. NAME OF CEMETERY OR CREMATORY
MAYO METH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MAYO AA MD | | | | |
| 24. FUNERAL DIRECTOR
John M. Fay Jr & Sons | | | ADDRESS
Champion Rd | | | 25a. DATE REC'D. BY REGISTRAR
MAY 7 1979 | | 25b. REGISTRAR'S SIGNATURE
Barbara [Signature] | | | |

153
120
1
92

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-10010



10-10010

10-10010

10-10010

10-10010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **79-10677** **bst**

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| GEORGE WASHINGTON LANE | | | | MAY 17, 1979 | | *8:25 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | White | MONTH DAY YEAR
May 4 1914 | | 65 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | USA | | | ANNE ARUNDEL COUNTY MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | | Mechanic | | | Trucking | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | AA | | Pasadena | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7964 Catherine Ave. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST
George F. Lane | | | | FIRST MIDDLE LAST
Edith Crosby | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| Yes | | WW II | | 213.10.0056 | | | Mrs. Ruth V. Lane (Wife) 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> | | | | | | | | | |
| 492- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD - Post MYOCARDIAL INFARCTION</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>P. EMPHYSEMA</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> POST MORTEM <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> 19 <u>78</u> to <u>MAY 17</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>APRIL</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | |
| | | | | | | | | 5-17-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| BENITO MARTINEZ, M.D. | | | | 2932 MOUNTAIN ROAD, PASADENA, MARYLAND, 21122 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | May 21, 79 | | Cedar Hill Cem. | | CITY OR TOWN COUNTY STATE
Brooklyn Park AA Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
Singleton Funeral Home, Glen Burnie, Md. | | | | MAY 18 1979 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1001-2

MAY 17, 1974

WASHINGTON LANE

GEORGE



ANN ARUNDEL COUNTY
ANN ARUNDEL HOSPITAL
ANN ARUNDEL HOSPITAL
ANN ARUNDEL HOSPITAL

ANN ARUNDEL HOSPITAL

ANN ARUNDEL HOSPITAL

ANN ARUNDEL HOSPITAL

ANN ARUNDEL HOSPITAL

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ANN ARUNDEL HOSPITAL

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10678
REG. NO.

DST

| | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KENNETH ALBERT LANG | | | 2a. DATE OF DEATH
MAY 6, 1979 | | | 2b. HOUR
9:55 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 23, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY
Paint&Chem. (Ferndale) | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
GlenBurnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles A. Lang | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle A. Smith | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | | |
| 16b. SOCIAL SECURITY NO.
W.W. II 214227927 | | | 17. INFORMANT (wife)
Mrs. Mary L. Lang | | | ADDRESS Same as #13 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CVA. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital attended the deceased from <u>7/1/77</u> , 19 <u>77</u> , to <u>5/6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert B Kroopnick</i> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/8/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B KROOPNICK, MD. | | | 22e. ADDRESS
RANDALLSTOWN, MARYLAND
LIBERTY PLAZA SHOPPING CENTER | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
May 10, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Singleton</i> | | | ADDRESS
GlenBurnie, Md. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 8 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Patricia McBrady</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3- retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3- should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

87-10018

DET

9:55A

MAY 5, 1979

KENNETH ALBERT LANG

MAY 28, 1928

White

Male

ANNE ARUNDEL COUNTY

U.S.A.

Maryland

NORTH ARUNDEL HOSPITAL

OLIV BURNIE

406 Annapolis Blvd.

Green/water

U.S.A.

Maryland

A. Smith

Maryland

Land

A.

Charles

Same as 87

(w/ta)

Mrs. Mary L. Lang

W.R. 11 21222222

See

LIBERTY PLAZA SHOPPING CENTER
RANDALLSTOWN, MARYLAND

ROBERT B KROBONICK, MD.

Baltimore City

London Park

10, 1979

MD

Standard Funeral Home, Glenview, Md.

MAY 8, 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10679

| | | | | | |
|--|--|--|---|---------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Lillian M Larrimore | | 5-26-79 | | 11:55 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| F | W | 10-21-18 | 60 | MONTHS DAYS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7c. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD | USA | | H.A.C. MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Arnold | 1510 Kane Drive Way | Housewife | Home | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS | |
| MD | Prince Georges | | | Rural | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| Julius Akerstrom | Christina | 16a. SOCIAL SECURITY NO. 212 097361 | | | |
| 17. INFORMANT | | 17a. ADDRESS | | | |
| Wm S. Larrimore | | - 10 + 11 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung c 1629 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) mediastinal metastases | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| Carl R. Holtschuh | MD | | 5-28-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| HOLTSCHUH, KARL | 104 Forbes ST - Annapolis | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Buried | 5/29/79 | Bethel Natl Cem | Bethel | MD | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Robert S. Ranaivosoa | May 31 1979 | | | | |

85001-95

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 79-10680 | |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | | 20. DATE OF DEATH MONTH DAY YEAR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | 20. DATE OF DEATH MONTH DAY YEAR | | |
| John E Lawrence | | | 5 14 79 7 05 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| male | cauc | 1 28 19 | 60 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | USA | | Anne Arundel, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | Anne Arundel General Hospital | | Fire Department | | Retired |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Anne Arundel | Lothian | 22 Patuxent Mobil Estates | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| John E. Lawrence Sr. | | ? McGaw | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| Yes | | Will & Korea 177-14-5139A | | 6007 Ioby Drive Ronald S. Pfeltz, Camp Springs, Md, 20031 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 73, to May 14, 19 79, that (I) (we) lost saw the deceased alive on May 13, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | |
| Stanley P. Watkins | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Stanley P. Watkins | | 121 Cathedral Street Annapolis, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 05-16-79 | | Md. Nat. Mem. Park | |
| 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Laurel, | | P.G. | | Maryland | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | |
| Beall Funeral Home, 1212 West St., Anna., Md. | | | | MAY 18 1979 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |
| [Signature] | | | | | |

BP

08801-01

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27

1. NAME OF THE ORGANIZATION U.S. DEPARTMENT OF AGRICULTURE
2. NAME OF THE PROJECT RESEARCH
3. NAME OF THE PERSON DR. J. W. HARRIS

4. ADDRESS OF THE PERSON 1000 N. 10TH ST. SUITE 100

5. CITY AND STATE MINNEAPOLIS, MINN.

6. DATE OF BIRTH 1910

7. DATE OF DEATH 1970

8. DATE OF INTERVIEW

9. DATE OF DEATH 1970

10. DATE OF INTERVIEW

11. DATE OF DEATH

12. DATE OF INTERVIEW

13. DATE OF DEATH

14. DATE OF INTERVIEW

15. DATE OF DEATH

16. DATE OF INTERVIEW

17. DATE OF DEATH

18. DATE OF INTERVIEW

19. DATE OF DEATH

20. DATE OF INTERVIEW

21. DATE OF DEATH

22. DATE OF INTERVIEW

23. DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10681 DST

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--------------------------------------|--|-----------------|--|--------|--|------|--|-------|--|--|--|--|--|--|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| HOWARD | | M. | | | | MALONE | | MAY 25, 1979 | | | | | | | | | | 10:27 ^A | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | | | |
| Male | | White | | 8-31-07 | | 71 | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Mass | | USA | | | | | | ANNE ARUNDEL COUNTY MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | | | | | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | | | | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Shipping Dept Warehouse | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STREET ADDRESS | | | | | | | | | | | | | | | | | | 13b. CITY AND TOWN | | | | | | | |
| 9501 Road 28-Apt 901 | | | | | | | | | | | | | | | | | | Weymouth | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Carmelina Malone | | | | | | | | | | | | | | | | | | Michaela Nickerson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | | | | | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | | | | | | | | | | | | | | | 028076648 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory arrest
410-
DUE TO, OR AS A CONSEQUENCE OF Acute myocardial infarct
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF Atrial cluery
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | | | | | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | | | | | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | | | | | | | | 5/25/79 5/25/79 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25/79 19, to 5/25/79 19, that (I) (we) lost saw the deceased alive on 5/25/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed this certificate after viewing the body after death. | | | | | | | | | | | | | | | | | | 22b. SIGNATURE | | 22c. DEGREE | | | | 22d. DATE SIGNED | |
| | | | | | | | | | | | | | | | | | | M.D. | | | | 5/25/79 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | | | 22f. ADDRESS | | 22g. MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | |
| JORGE B. RAMIREZ, M.D. | | | | | | | | | | | | | | | | | | 325 HOSPITAL DR., GLEN BURNIE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | | | | | | | | | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | | |
| Removal | | | | | | | | | | | | | | | | | | 5/26/79 | | Beth Funeral Home | | Baltimore, Mass. | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | | 24b. ADDRESS | | 24c. DATE AND TIME OF REGISTRATION | | | | | |
| Robert S. Bananec | | | | | | | | | | | | | | | | | | Severna Park, Md. | | MAY 29 1979 | | | | | |

100-100-100

100-100-100 MAY 25 1975



ELITE RANGEL COUNTY

NORTH RANGEL HOSPITAL

GRASS BURNING

Grass burning
Grass burning
Grass burning

Grass burning

100-100-100 100-100-100



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10682

1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|--|--|---|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Gary | | Martin | | | | | | 5 | | 23 | | 19 | | 79 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| male | white | 1 26 55 24 | | YRS | | MONTHS | | DAYS | | HOURS | | MIN | | 5 | | 23 19 79 | |
| 7b. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| OHIO | | U. S. A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Ann e Arundel County MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Glen Burnie | | North Arundel Hospital | | SOLDIER | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| W. VA. | | | | HUNTINGTON | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 821 1/2 WASHINGTON ST. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| GARY E. MARTIN | | MARY (NMN) ADAMS | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| | | 285-56-8298 | | BRENDA G. MARTIN-HUNTINGTON, W. VA. ST. | | 821 1/2 WASHINGTON | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple visceral and skeletal injuries | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 8169 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 30 AM 5/23 19 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | trapped in overturned truck cab | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | ramp Rt10 to East Rt710, AA county MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
Assistant | | DATE
SIGNED | | 5/24/79 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | 111 Penn St. Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | FAMILY LOT | | HUNTINGTON W. VA. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| L. B. Carson | | Baltimore | | JUN 12 1979 | | History McCreedy | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10085-9



State of Vermont and Federal Injuries

10085-9

State of Vermont and Federal Injuries

10085-9

10085-9

b

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-10683
REG. NO.

DST

| | | | | | | | | |
|--|---|---|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPHINE <i>sophia</i> MARTIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 28 79 | | | 2b. HOUR
12:45 P M | | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
127 Brookfield Rd. 21122 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Docksins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-28-5027 | | 17. INFORMANT
ADDRESS
Mary E. Stinchcomb 129 Brookfield Rd., Pasadena Md. 21122 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line 18a, 18b, and 18c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cat Cell Carcinoma
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) leukemia with bone
DUE TO, OR AS A CONSEQUENCE OF
(c) metastases
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
HOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/29/79 to 5/29/79, that (I) (we) lost
saw the deceased alive or
breath (I) (we) did not touch the body after death
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | |
| 22b. SIGNATURE
<i>Anastacio E. Subong</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/29/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTACTO E. SUBONG | | | | 22e. ADDRESS
1406 Crain Highway S. Glen Burnie, Md. 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/31/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk., Anne Arundel, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Bartholomew McCready</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10684

| | | | | | | | | | | |
|--|--------------|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BEATRICE L. MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 31 79 | | | 2b. HOUR
2:30 P.M. | | | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
APR 29 96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. UNDER 74 HRS
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Franklin Penna. USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| 13a. STATE
Md. | | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Gambrills | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1571 Defense Hwy. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Steele | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
Karl M. Steele | | ADDRESS
3202 Nicholson St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CONGESTIVE Failure
410 -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) ISM
Hystisville Md.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs
3 hrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/31 1979, to 5/31 1979, that (I) (we) last saw the deceased alive on 5/31 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A. R. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/1 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT BIERN MD | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
6/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Crown Hill - S | | 23d. LOCATION
CITY COUNTY STATE
Southview P. Kentlands | | | |
| 24. FUNERAL DIRECTOR
NAME
Handley | | | ADDRESS
12 Ridge Line Annapolis Md | | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1979 | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |

BP _____

48801-2

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10685

| | | | | | | | | | |
|--|-----------------------------|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| HELEN | | MATECKI | | 5-5-79 | | 7 AM | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | WHITE | 4/15/86 | | 93 | | YRS MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| POLAND | U.S. | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Brooklyn Park | | HAMMONDSLANE N.C. | | | | HOMEMAKER | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| MD. | | BROOKLYN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3617 BROOKLYN AVE. | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| CASIMER | | | | BARBARA | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| NO | | 214 54 8835 | | Martha Fialkowski Balto. 21225 Brooklyn Ave. | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute CVA</u>
<u>4292</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD - Periph Vasc Disease</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Two weeks</u> | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1978</u> to <u>May 5, 1979</u> , that (I) (we) last saw the deceased alive on <u>April 28, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>[Signature]</u> | | | | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| EWALDO WRISS M.D. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| BURIAL | | 5/8/79 | | Holy Cross cemetery | | Brooklyn | | A.A. Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME George J. Gonca 4001 Ritchie Hwy | | | | ADDRESS Balto 21225 | | MAY 11 1979 | | <u>[Signature]</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

45

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10686
 REG. NO.

1. FOR
 STATE
 REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL NMI MC CREERY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 16, 1979 | | 2b. HOUR
1:10 ^A |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 8, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truckdriver (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Jordan Lumber Co. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
GlenBurnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
7855 Crilley Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Milton McCreery | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hannah Mae Robinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | 17. INFORMANT (wife) ADDRESS Same as #13
Mrs. Anna M. McCreery | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Lung Rt. apex
1629
(b) Ch. Obs. Pulmonary Disease
(c) DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
AS EVID - PULCS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-28-79 to 5-15-79, that (I) (we) last saw the deceased alive on 5-15-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) said (did not view the body after death). | | | | | |
| 22b. SIGNATURE
S. Bhatiani | | DEGREE
MD | | 22c. DATE SIGNED
5-16-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SWADESH K BHATIANI M.D. | | 22e. ADDRESS
205 BALTIMORE ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
May 18, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1979 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

BP
DHMH: 17
(VRA 15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10687

| | | | | | | | | |
|---|---------------------|---|--|---|---|--|---|--------------------------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>PARIS</i> | MIDDLE
<i>L.</i> | LAST
<i>McGrath</i> | 2a. DATE KNOWN
OF
DEATH ESTI-
MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | 2b. HOUR
M |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6 7 71</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>7</i> YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE
PRONOUNCED
DEAD | MONTH DAY YEAR
<i>5 6 79</i> | 2d. HOUR
M |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
<i>Wash., D. C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Anne Arundel General</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
<i>Dependent</i> | | 12b. KIND OF BUSINESS
OR INDUSTRY |
| 13a. STATE
<i>Va.</i> | | 13b. COUNTY | 13c. CITY OR TOWN
<i>Alexandria</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>7818 Eagle Avenue</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Paul C. McGrath</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Linda Wear</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | | | |
| 16b. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
ADDRESS
<i>4700 Homer Ave., Suitland, Md.
Peter J. McGrath, Uncle.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
<i>8309</i> IMMEDIATE CAUSE (a) <i>Drowning</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 5 6 79</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
<i>Boatlifted</i> | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
<i>Chesapeake Bay</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Chesapeake Bay Suitland P.G. MD</i> | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL
SIGNATURE
<i>E. L. White</i> | | TITLE (SPECIFY)
M.D. <i>Depot</i> | | MEDICAL EXAMINER | | DATE
SIGNED <i>5-6-79</i> | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>E. L. White</i> | | ADDRESS
<i>Annapolis Md</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5-10-79</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>CEdar Hill Cem.</i> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suitland, P.G., Maryland</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robt E Wilhelm</i> | | ADDRESS
<i>4308 Suitland Rd., Suitland, Md.</i> | | 25a. DATE
MAY 14 1979 | | | | |

10071-2

MAY 1952

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10688

| | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--------------------------------|--|------------|--|--------------|--|---------------|--|
| FOR
1- STATE
REGISTRAR | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Paul | | MIDDLE
C | | LAST
McGrath | | 2a. DATE KNOWN
OF ESTI.
DEATH MATED | | MONTH
5 | | DAY
6 | | YEAR
1979 | | 2b. HOUR
P | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 21 50 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
28 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD | | MONTH
5 | | DAY
6 | | YEAR
1979 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Sheet Metal Worker | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE
Va. | | 13b. COUNTY | | 13c. CITY OR TOWN
Alexandria | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7818 Eagle Avenue | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul P. McGrath | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice M. Abbott | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Unknown | | 17. INFORMANT
ADDRESS
4700 Homer Ave., Suitland, Md
Peter J. McGrath, Brother, | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Instant | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
(PM) 5 6 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Back Capricious | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME
STREET, FACTORY, FARM, ETC.)
Sheepkillers Rd. | | 21f. LOCATION
CITY OR TOWN
Suitland | | COUNTY
MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
E. L. H. H. H. H. H. | | TITLE (SPECIFY)
M.D. Depo 19 | | MEDICAL EXAMINER | | DATE
SIGNED 5-6-79 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
E. L. H. H. H. H. | | ADDRESS
Annapolis, Md | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN
Suitland, P.G., Md. | | COUNTY | | STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robt E Wilhelm | | 4308 Suitland
Rd., Suitland, Md. | | 25a. DATE
MAY 14 1979 | | 25b. REGISTERED
REGISTERED | | | | | | | | | | | |

00001-01



MAY 1 1953

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17
(VR A15 ME 1)
30M 7/73

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10689

| | | | | | | | | |
|---|------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Paul P. McGrath | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 5 6 1979 | | | 2b. HOUR 9 AM | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH 3 DAY 16 YEAR 21 | 6. AGE (IN YEARS)
LAST BIRTHDAY 58 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH 5 DAY 7 YEAR 1979 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Annapolis Co MD. | | |
| 10. CITY OR TOWN OF DEATH
Alex | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chesapeake Bay | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Gas Station - Manager | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Va. | | | | 13b. CITY OR TOWN
Alexandria | | 13c. STREET ADDRESS
7818 Eagle Avenue | | |
| 14. FATHER'S NAME
FIRST Frank MIDDLE McGrath LAST McGrath | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE A. LAST Tobin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W.II 578 10 3840 | | 17. INFORMANT (Wife) ADDRESS
Alice M. McGrath, 4700 Homer Ave. Suitland, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 5-6-1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Bank Collapse | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Chesapeake Bay | | 21f. LOCATION
STREET CITY OR TOWN Alex COUNTY PRGO STATE | | | |
| 22a. I certify that I took charge of the remains described above, held as Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
E. Linhardt | | | TITLE (SPECIFY)
Deputy | | | DATE SIGNED
5-7-79 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
E. Linhardt | | | ADDRESS
Annapolis, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN Suitland, P.G., Md. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME Robt E Wilhelm ADDRESS 4308 Suitland Rd., Suitland, Md. | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 14 1979 | | | | |

10-10608



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10-10608

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| <div style="text-align: right;">REG. NO. 79-10690</div> | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Mary</i> | | | | FIRST MIDDLE LAST <i>LOIS McMillan</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5/26/79</i> | | 2b. HOUR <i>10¹⁵ PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9 23 09</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Indiana</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerical - Electrical Union</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Anne Arundel</i> | | 13c. CITY OR TOWN <i>Edgewater</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>1649 Elkridge Rd.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Silvers</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie Huffman</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>N/a</i> | | 17. INFORMANT <i>Lee R. Mc Millan</i> | | 18. ADDRESS <i>4717 Cardinal Ave., Beltsville, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Colon Carcinoma</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>12/13</i> 19 <i>78</i> , to <i>5/26</i> 19 <i>79</i> , and that in my (2) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Enser W. Cole III</i> | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>5/27/79</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ENSER W. COLE III</i> | | | | 22e. ADDRESS <i>121 CATHEDRAL ST ANNAPOLIS</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5-30-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Beall Funeral Home, 1212 West St., Annapolis, Md.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 31 1979</i> | | 25b. REGISTRAR'S SIGNATURE <i>Johny McBrady</i> | | | |

00001-01

(M)

John A. Smith

1944

1944

John A. Smith

John A. Smith

John A. Smith

John A. Smith

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John A. Smith

John A. Smith

John A. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10691
DST
2b. HOUR 4:00 A.M.

| | | | | | |
|--|------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
JESSE ALLEN MEDFORD, JR. | | 2a. DATE OF DEATH
MAY 27, 1979 | | 2b. HOUR
4:00 A.M. | |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
JULY 18, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
TECH. WRITER | | 12b. KIND OF BUSINESS OR INDUSTRY
CIVIL SERV. | | | |
| 13a. STATE
TENNESSEE | | 13b. COUNTY
SHELBY | | 13c. CITY OR TOWN
MEMPHIS | |
| 14. FATHER'S NAME
JESSE A. MEDFORD, Sr. | | 15. MOTHER'S MAIDEN NAME
LOUISE WILLIAMS | | 16. ADDRESS
Same as # 13 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
214-05-3001 | | 17. INFORMANT
MRS. MARY G. MEDFORD (WIFE) | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRCUMFLEXION OF THE BOWEL
1590
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/27/79 , 19 79 , to 5/27/79 , 19 79 , that (I) (we) lost
saw the deceased alive on 5/27/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Robert B. Kroopnick | | 22c. DATE SIGNED
5/27/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B. KROOPNICK, M.D. | | 22e. ADDRESS
205 BALTIMORE ANNAPOLIS BOULEVARD
GLEN BURNIE, MARYLAND 21061 | |

| | | | |
|---|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
30 MAY '79 | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PK. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MD. |
| 24. FUNERAL DIRECTOR
NAME SINGLETON FUNERAL HOME ADDRESS GLENBURNIE, MD. | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1979 | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100-10001

4:00

MAY 27, 1979

MEDFORD, MA.

ALLEN

JESSE

ANNE ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

GLEN BURNIE

100-10001

100-10001

100-10001

305 BALTIMORE ANNAPOLIS BOULEVARD
GLEN BURNIE, MARYLAND 21061

ROBERT E. KROGNICK, M.D.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10692

| FOR
1- STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 79-10692 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | 2b. HOUR | |
| w Lee | | MEEHAN | | | | | | 2b. DATE KNOWN
OF DEATH | | 2b. HOUR | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | |
| Male | | White | | 9 13 16 | | 62 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR | |
| Maryland | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | Anne Arundel, Md. | | 5 14 19 79 | | 11 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| New Bernie | | North Arundel Hospital | | Supervisor Commercial Credit | | Glen Burnie, Md. 21061 | | 403 Secluded Post Circle | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | |
| Willie | | Clara | | NO | | 212-10-5676 | | May Clara Grompler | | Pasadena, Md. 21122 | |
| 19. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) | | 20. IMMEDIATE CAUSE (a) | | 20. IMMEDIATE CAUSE (b) | | 20. IMMEDIATE CAUSE (c) | | 21. DATE OF OPERATION | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 410- Impaired Cardiac Function | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 23a. EXTERNAL CAUSE WAS | | 23b. TIME OF INJURY | | 23c. HOW INJURY OCCURRED | | 24. INJURY OCCURRED | | 25. LOCATION | |
| 410- Impaired Cardiac Function | | UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | |
| 26a. I certify that I took charge of the remains described above, held on | | 26b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | 26c. death resulted from | | 26d. Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 27a. ACTUAL
SIGNATURE | | 27b. TITLE (SPECIFY) | |
| E. Linbeck | | M.D. Repud | | MEDICAL EXAMINER | | DATE SIGNED 5-14-79 | | 28a. EXAMINER'S NAME
(TYPE OR PRINT) | | 28b. ADDRESS | |
| 29a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 29b. DATE | | 29c. NAME OF CEMETERY OR CREMATORY | | 29d. LOCATION | | 30a. DATE REC'D. BY REGISTRAR | | 30b. REGISTRAR'S SIGNATURE | |
| Cremation | | 5/17/79 | | Security Process, Inc. | | Catonsville Baltimore Maryland | | MAY 15 1979 | | L. J. Kelly | |
| 31. FUNERAL DIRECTOR | | 32. NAME OF FUNERAL HOME | | 33. DATE REC'D. BY REGISTRAR | | 34. REGISTRAR'S SIGNATURE | | 35. DATE REC'D. BY REGISTRAR | | 36. REGISTRAR'S SIGNATURE | |
| Mountain and Tuck Neck Roads | | Pasadena, Md. 21122 | | MAY 15 1979 | | L. J. Kelly | | MAY 15 1979 | | L. J. Kelly | |

9-10002

Handwritten text, possibly a name or title.

Handwritten text, possibly a date or reference number.

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Handwritten text, possibly a name or title.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-10693 | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Luther F. V. Meyers | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-2-79 | | | 2b. HOUR
2:30 P M | | |
| 3. SEX
M. Male | | 4. RACE
W Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 14, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 | | IF UNDER 1 YEAR
MONTHS DAYS
YRS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland Manor Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Meter Reader | | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. G & E | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7847 Americana Circle | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Meyers | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Matilda | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW 1 | | 16b. SOCIAL SECURITY NO.
212-05-4875 | | 17. INFORMANT Daughter ADDRESS Glen Burnie, Md.
Mrs. Helen Hartman, 501 Saratoga Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute MS
496-
DUE TO, OR AS A CONSEQUENCE OF (b) COPD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
10 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-2 19 78 , to 5-2-79 , that (I) (we) lost saw the deceased alive on 5-2-79 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
PEARL MAN | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-2-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PEARL MAN | | | | | | 22e. ADDRESS
5400 Old Court Rd Rensselaer | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5 May 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, AA, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
James S. Kirkley, Glen Burnie, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1979 | | 25b. REGISTRAR'S SIGNATURE
D. J. Kelly | | | |

MEDICAL CERTIFICATION

12-10003

V. I.

SA

U. S. DEPARTMENT OF JUSTICE

W. I.

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

RECEIVED

20% COLLECTIBLE



[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10694

1. FOR
REGISTER

| | | | | | |
|--|---------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY E. MCWILLIAMS | | | 2a. DATE OF DEATH MONTH DAY YEAR
05 02 79 | | 2b. HOUR
120^P |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
09 10 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County | | 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Annel General Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Navy | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel E. Good | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Kappler | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 215-07-7946
215-07-1085 | |
| 17. INFORMANT
Mrs. Edith M. Gembicki | | ADDRESS
-7669 St. Pasadena | | City or Town
Md. 21122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Atherosclerotic Cardiovascular Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (1) (this hospital) attended the deceased from September 19 79 to 5/2 79 , that (1) (we) last saw the deceased alive on 5/2/79 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
Eusebio W. Cole III | | DEGREE | | 22c. DATE SIGNED
5/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ENSER W. COLE III | | 22e. ADDRESS
121 CATHEDRAL ST. ANNAPOLIS Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-5-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cem. | |
| 23d. LOCATION
CITY OR TOWN
Balto. Md. | | STATE
Md. | | 23e. DATE REC'D. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc | | ADDRESS
6415 Belair Rd. -21206 | | 25. REGISTRAR'S SIGNATURE
May 8 1979 | |

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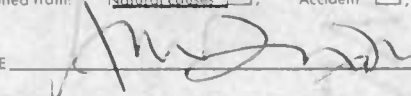

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **79-10695**

1- STATE REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) DENNIS C. MORAN | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 5 DAY 5 YEAR 1979 | | | | 2b. HOUR
6:15 p.m. | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH 1 DAY 19 YEAR 1951 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH 5 DAY 5 YEAR 1979 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Mayo | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Valley View Dr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Mayo | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST Thomas MIDDLE Roger LAST Moran Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST Delores MIDDLE Epp LAST Epp | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-56-1276 | | 17. INFORMANT ADDRESS
Delores Moran Same as 13 e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Cirrhosis of the liver
IMMEDIATE CAUSE (a) 5713 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) }
DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input type="checkbox"/> , <u>Inquiry</u> <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , <u>Accident</u> <input type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined manner</u> <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
Assistant | | M.D. MEDICAL EXAMINER | | DATE SIGNED 5-6-79 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
5-8-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Cem. | | 23d. LOCATION
CITY OR TOWN Davidsonville COUNTY A.A. STATE Md. | |
| 24. FUNERAL DIRECTOR
NAME Hardesty ADDRESS 12 Ridgely Ave. Annapolis Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 9 1979 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR REMOVAL TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(VR A15 ME (5))
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10696
REG. NO. | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SARAH Agnes Mosher | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 6 1979 | | 2b. HOUR
1:40 PM | |
| 3. SEX
Female | | 4. RACE
CAU | | 5. DATE OF BIRTH MONTH DAY YEAR
Sep 3 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
92 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penn | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BAY BERRY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
730 - PINE TRAIL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
Penn | | 13b. COUNTY
DELAWARE | | 13c. CITY OR TOWN
Collingsdale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
109 UPLAND TERRACE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JAMES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ellen | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
190-16-8698-B | | 17. INFORMANT ADDRESS
Beatrice-Walsh 730 Pine Trail ARMY MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 436- Debilitation
DUE TO, OR AS A CONSEQUENCE OF (b) Old Age - Advanced Senility
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Cerebral Vascular Disease & STROKE - 4 years Ago | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 YEARS | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1974, to MAY 6 1979, that (I) (we) last saw the deceased alive on MAY 4 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
T.C. Cullis MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6 MAY 79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T.C. CULLIS | | 22e. ADDRESS
7 Riggs Ave Severna Park Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/9/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Hollywood Cem. | | 23d. LOCATION CITY OR TOWN
Yeadon | | COUNTY
Pa. | | STATE | |
| 24. FUNERAL DIRECTOR NAME
Robert J. Benavente | | ADDRESS
Severna Park, Md | | 25a. DATE RECEIVED BY REGISTRAR
MAY 6 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

MEDICAL CERTIFICATION

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U.S. AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10697
REG. NO. | | DST | | | |
|---|--|--|--|--|---|--|---|--|---|---|--|---|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} Mary ^{MIDDLE} Rose ^{LAST} Moss ^(also) ROSE | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 8, 1979 | | | | 2b. HOUR
10:35 A | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
Nov. 21, 1892 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Louisiana | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY AnneArundel 13c. CITY OR TOWN Glen Burnie | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
135 North Meadow Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Victor H. Sibille | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Virginia Clay | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWI | | | | | 16b. SOCIAL SECURITY NO.
096-16-3608 | | 17. INFORMANT ADDRESS
Kenneth C. Moss 1409 Quebec Street Adelphi, Maryland 20783 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic Ketoacidosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Cerebrovascular Accident</u> | | | | | | | | | | days | | | | | |
| (c) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3, 19 79, to 5-8, 19 79, that (I) (we) last saw the deceased alive on 5-8-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Sang C. Doh</u> DEGREE | | | | | | | | | | 22c. DATE SIGNED
5-8-79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SANG C. DOH, M.D. | | | | | | 23a. ADDRESS
95 AQUAHART RD., GLEN BURNIE, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
May 11, 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Montgomery, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Hines/Rinaldi Funeral Home | | | | | | 11800 New Hamp. Ave. S. S. Md. 20904 | | 25a. DATE
MAY 14 1979 | | 25b. REGISTERED SIGNATURE
<u>Anthony M. Brady</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-10698 | | | |
|---|--|---|--|---|--|--|--|
| FOR
1. STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Cora Bell Nogule | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 29 79 | | | |
| 3 SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 28 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Laurel Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Crownsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown Hammond | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | 13e. STREET ADDRESS
Box 917 Herald Harbour | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
no | | 17. INFORMANT
ADDRESS
Oliver Nogule Box 917 Crownsville Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> 19 <u>79</u> , to <u>5/29</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Richard I. Hochman</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard I. Hochman, M.D. P.A. | | | | 22e. ADDRESS
16 Murray Avenue, Annapolis, Md. 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Our Lady of Fields | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Millersville Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hardesty Funeral Home 12 Ridgely Ave. Ann. Md. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JUN 4 1979 <u>[Signature]</u> | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **79-10699**

| | | | | | | | | | | |
|--|---|---|-------------------|--|---|---|--|-----|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 'ANNIE W. Norris | | | | | 5 11 79 | | | | | 6:15 a.m. |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | White | MONTH DAY YEAR
09 04 85 | | | 93 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| St Mary Co. Md. | USA | | | | Anne Arundel Co. MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Annapolis | Anne Arundel General Hosp. | | | | clerk | | US Gov't. | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | A.A. Co. | Davidsonville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3110 Davidsonville Rd. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | |
| Barber | | Mary Forest | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(# YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | |
| no | | 578 14 7383 | | Mary V. Snyder | | 3110 Davidsonville Rd.
Davidsonville Md. 21035 | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u>
4349
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Generalized atherosclerosis</u>
Years
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CCHF</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>5/10/79</u> to <u>5/11/79</u> , and that (II) (we) lost <u>5/11/79</u> saw the deceased alive on <u>5/10/79</u> and that (III) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | |
| George Samaras | | MD | | 5/11/79 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| George Samaras | | 1616 Forest Dr. Annapolis, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 5/14/79 | | Arlington National | | Arlington Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Hardesty Funeral Home | | 12 Ridgely Ave. Ann. Md. | | MAY 16 1979 | | [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-10700
REG. NO. DST
May 28, 1979 5:30 P.M.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Elvira Louise Ogle | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 28, 1979 | | 2b. HOUR
5:30 P.M. | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
Sept. 6, 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10 CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
417 Rodgers Ave. |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Henry Clinton Stallings | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Amelia Dubberka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
n/a | | 17 INFORMANT
ADDRESS
Glen Burnie, Md.
Mrs. Carolyn J. Hilton (daughter) | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac asystole
4392
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
pulm. fibrosis & emphysema | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/26 19 79 , to 5/28 19 79 , that (I) (we) last saw the deceased alive on 5/28 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>James J. Benjamin</i> | | DEGREE
<i>MD</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
5/30/79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James J. Benjamin M.D. | | 22e. ADDRESS
517 Empire Towers, 7300 Ritchie Hwy.
Glen Burnie, Md. 21061 | |

| | | | |
|--|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
June 1, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. |
| 24 FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1979 | |

10-10-00

Sept. 5, 1902

White

Female

Barland

U.S.A.

Housewife

own home

Barland

A.A.

Barland

417 Rogers Ave.

Citation

Stralinger Evans

Amelia

Barland

Mr. Carolyn G. Linton (daughter)

21-12-73

Yes

No

Done

1, 1902

Barland

Stralinger Evans, M. (M. 1, 1902)

Amelia Evans, M. (M. 1, 1902)

Barland, M. (M. 1, 1902)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10701
REG. NO. | |
|--|--|---|--|---|--|---|--|--|-----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>RICHARD F OWENS</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>MAY 19 1979</i> | | | 2b. HOUR
<i>3:15</i> P M | | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>Negro</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 2 1904</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>75</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>ANNE ARUNDEL COUNTY MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>ANNAPOLIS</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ANNE ARUNDEL GENERAL HOSPITAL</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>A.A.</i> | | 13c. CITY OR TOWN
<i>ANNAPOLIS</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>1825 Bowman Drive</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>GRANT OWENS</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>SOPHIA OWENS</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>212-10-2819</i> | | 17. INFORMANT
ADDRESS
<i>ARISTINE SISCOE 1825 Bowman Dr. Annapolis, Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Advanced Chronic Brain Syndrom</i>
<i>5712</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>Chronic Alcoholism</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <i>MANY YEARS</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>- 5 MO -</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Cirrhosis of Liver - Alcoholic</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>22 Feb</i> , 19 <i>79</i> , to <i>17 April</i> , 19 <i>79</i> , that (I) (we) lost
saw the deceased alive on <i>17 April</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (they) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>T. C. Callis</i> | | | | DEGREE
<i>M.D.</i> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>T. C. Callis</i> | | | | 22e. ADDRESS
<i>7 Aggs Ave Severna Park Maryland 21146</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>5-23-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>PINELAWN MEM. PARK</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Annapolis A.A. Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 24 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>P. J. H. H. H.</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and that it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10702

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLARD G. OWENS | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 2, 1979 | | 2b. HOUR
3:23 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 17, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co., MD. | |
| 10. CITY OR TOWN OF DEATH
N. Linthicum | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11 Circle Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Crane Oper. | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Port Auth. |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
N. Linthicum | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Curtis Owens | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Edwards | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W.II 214 16 8019 | 17. INFORMANT
ADDRESS
Emilie D. Owens, same as 13e | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a). CHRONIC OBSTRUCTIVE PULMONARY DISEASE
496-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
CHRONIC HEPATITIS | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5-18, 19 70, to 5-2, 19 79, that (I) (we) saw the deceased alive on 5-2, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Morton M. Krieger, M.D. | | DEGREE | | 22c. DATE SIGNED
5/3/79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton M. Krieger, M.D. | | 22e. ADDRESS
615 Hammonds Lane (21225) | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/5/79 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn, A.A. Co., Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George J. Gonce, 4001 Ritchie Hg., Baltimore | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1979 | | |

100-10705

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624

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10703

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ORALEE VIVIAN PALMER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 22, 1979 | | | 2b. HOUR DST
10:35A M | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 18, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Practical Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4140 Mariban Court | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jenning Lee Daulton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Addie B. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 26 2111 | | 17. INFORMANT
ADDRESS
Gary Palmer, 757 217th St., Pasadena, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
4380
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH
GAVE RISE TO IMMEDIATE
CAUSE (a), stating the
underlying cause last | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Lactate Acidosis, ASCVD</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>79</u> , to <u>5/22</u> , 19 <u>79</u> , that (I) (we) last
saw the deceased alive on <u>5/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert B. Kroopnick</u> | | | DEGREE
<u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>5/22/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B. KROOPNICK, M.D. | | | 22e. ADDRESS
205 BALTIMORE-ANNAPOLIS BOULEVARD
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5/25/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk., A.A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce, 4001 Ritchie Hg., Baltimore | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Petrykalsky</u> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

92-10703

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Jan. 18, 1967

Wife

Female

U.S.

Virginia

Residence

Domestic law suit

Alaska

ALL TO SUE FOR DIVORCE AND ALIMONY

Re

2

10-10-67

10-10-67

10-10-67

2

Wife

U.S. District Court, District of Columbia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10704

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) WILLIAM A PATE | | | 2a. DATE OF DEATH
Month 5 Day 1 Year 79 | | | 2b. HOUR
9A M | |
| 3. SEX
MALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
2-25-18 | | 6. AGE (In years last birthday)
61 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Anne Arundel Md. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1736 Old General's Highway | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Government State Gov't | |
| 13a. USUAL RESIDENCE (If deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
1736 Old General's Highway | | | | | | | |
| 14. FATHER'S NAME First Alfred Middle Belden Last Pate | | | 15. MOTHER'S MAIDEN NAME First Sabra Middle C. Last Moxley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
406 07 0509 | | 17. INFORMANT
Mary Roney Pate Address #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Attack
410 - DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ASCD
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 76 , to present , 19 79 , that (I) (we) last saw the deceased alive on 11/28 , 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. Pate | | | | DEGREE
MD | | 22c. DATE SIGNED
5-1-79 | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT D BIRN | | | | 22e. ADDRESS
521 CATHEDRAL ST | | | |
| 23a. BURIAL CREMATION REMOVAL (Type)
Cremation | | 23b. DATE
5/2/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Brentwood P.G. Md. | |
| 24. FUNERAL DIRECTOR
John M. Taylor & Sons | | | | ADDRESS
Annapolis, Md. | | 25a. REC'D BY REGISTRAR
MAY 7 1979 | |
| | | | | DATE | | 25b. REGISTRAR'S SIGNATURE
Henry Shabundy | |

MEDICAL CERTIFICATION

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10-10704

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10705

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--------------------------------|--|--|--|----------------------|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>Louise</i> | | MIDDLE
<i>S.</i> | | LAST
<i>Payne</i> | | 2a. DATE KNOWN
OF DEATH | | 2b. HOUR | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 10 18</i> | | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>61</i> YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD
<i>5 18 1979</i> | | 2d. HOUR
<i>A</i> | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
<i>Wash., D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTO.</i> | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Anne Arundel General</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
<i>Teacher</i> | | 12b. KIND OF BUSINESS
OR INDUSTRY
<i>Educational</i> | | | | | | | | | |
| 13a. STATE
<i>Fla.</i> | | 13b. COUNTY
<i>Puntagorda</i> | | 13c. CITY OR TOWN
<i>Puntagorda</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>70 Taylor Road</i> | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Charles H. Gardner</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Catherine Atwood</i> | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>arteriosclerotic CHD</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>4-29-79</i> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>E. Linhardt</i> | | TITLE (SPECIFY)
M.D. <i>Deputy</i> | | MEDICAL EXAMINER | | DATE
SIGNED <i>5-18-79</i> | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>E. Linhardt</i> | | ADDRESS
<i>Annapolis, Md</i> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Removal</i> | | 23b. DATE
<i>5/18/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Anatomy Board</i> | | ADDRESS
<i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JUN 1 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Jeffrey McCreedy</i> | | | | | | | | | |

20501-05



[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-10706
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Pauline Catherine Phipps | | 2a. DATE OF DEATH MONTH DAY YEAR
5 27 79 | | 2b. HOUR
3 ²⁸ P M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
March 14, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Blat. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lena unknown | | 16. STREET ADDRESS
12 German St. | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)
no | | 17b. SOCIAL SECURITY NO.
215-74-2230 | | 17. INFORMANT
Elaine King | | ADDRESS
256 Riverside Rd. Edgewater Md. | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs.
Year
Year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27, 1979, to 5/27, 1979, that (I) (we) lost s/he the deceased alive on above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph N. Friend | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/27/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | | 22e. ADDRESS
1616 Forest Dr. Annapolis, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/30/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie Md. | |
| 24. FUNERAL DIRECTOR NAME
Hardesty Funeral Home | | ADDRESS
12 Ridgely Ave. Ann. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 29 1979 | | 25b. REGISTRAR'S SIGNATURE
Rickey McCreedy | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO BALTIMORE CITY OR COUNTY OF DEATH: This certificate must be filed with the health department of the city or county of death within 72 hours after death.

20701-28

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10707
REG. NO. | | | |
|---|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) George Edgar Pickett | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 31, 1979 | | 2b. HOUR
5:15 A.M. | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25, 1979 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Edgewater | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
713 Londontown Rd. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician- Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Edgewater | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
713 Londontown Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Marshall A. Pickett | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace May Young | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 578-30-7572 | | 17. INFORMANT ADDRESS
Doris May Pickett same as 13a-e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1990
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
- | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 7 , 19 70 , to April , 19 79 , that (I) (we) lost saw the deceased alive on May 23 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Leymont W. Lott M.D. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Leymont W. Lott, Md. | | | | | | 22e. ADDRESS
Davidson, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(Burial) | | | | 23b. DATE
June 2, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Memo. Gardens | | 23d. LOCATION
CITY OR TOWN STATE
Davidsonville, M. | | | | | |
| 24. FUNERAL DIRECTOR
Beall Funeral Home, 1212 West St, Annp., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1979 | | 25b. REGISTRAR'S SIGNATURE
John H. Kennedy | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10708

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WELLER E. POLLARD | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 21 79 | | 2b. HOUR
4:30 | | REG. NO. DST | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-27-1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Store Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Goodyear | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severna Park | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
Rt. 1 Box 288A | | 14 FATHER'S NAME
FIRST MIDDLE LAST
Howard W. Pollard | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
173-056195 | | 17 INFORMANT
Mr. John Pollard - 1005 Barwood Ct. | | ADDRESS
Richmond, VA. 23226 | |
| CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute CHF
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) ACVD
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
① Septicemia ② UTI ③ Parkinson's Disease ④ Pulmonary aspiration | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1978 to 5/21 1979 , that (I) (we) last saw the deceased alive on 5/21 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bernardino A. Alonso, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
5/21/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bernardino A. Alonso, M.D. | |
| 22e. ADDRESS
1406 Crain Highway, S. Glen Burnie, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-24-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Richmond V.A. | |
| 24. FUNERAL DIRECTOR
NAME
Robert S. Barranco | | ADDRESS
Severna Park | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1979 | | 25b. REGISTRAR'S SIGNATURE
L. H. A. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the 72-hour order of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 5, 6 g533 7/23/79 gj

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10709

| | | | | | |
|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERTRUDE QUEEN PRICE | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 22 79 | | 2b. HOUR
6:50 P | |
| 3. SEX
FEMALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR
02 07 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
83 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Cou. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD. | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE COLLINS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH COLLINS | | 16. ADDRESS
Annapolis, Md. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-18-0979 | | 17. INFORMANT
NANCY QUEEN 1135 Madison St. Apt A3 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) ACVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1961 to 5-22-79 , that (I) (we) last saw the deceased alive on 1:50 PM 5-22-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
A.J. Allen | | 22b. DEGREE
MD | | 22c. DATE SIGNED
5-27-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.J. ALLEN | | 22e. ADDRESS
111 Cathedral St | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5-26-79 | | 23c. NAME OF CEMETERY OR CREMATORY
BREWER HILL CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
L. H. H. H. | |

20701-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | 79-10710 | DST | |
|--|--|------------------------------|--|--|------|--|--|---|--|---|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| George Anthony Pucciarella | | | | | | May 5, 1979 | | | | | | 7:00p M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | # UNDER 1 YEAR | | # UNDER 74 HRS. | | |
| Male | | White | | FEB. 22 1918 | | 61 | | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | |
| Pa. | | U. S. A. | | | | Anne Arundel County MD. | | | Glen Burnie | | North Arundel Hospital | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | 17b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | A. A. | | Glen Burnie | | | | YES | | 308 Maryland Ave. (21061) | | Ft. Meade | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT (wife) | | ADDRESS | | 17c. KIND OF BUSINESS OR INDUSTRY | |
| Angelo A. Pucciarella | | Lucia Lardieri | | Yes | | W.W. 11 136162490 | | Mrs. Caroline G. Pucciarella | | Same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CA Prattata</u>
185-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 years | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | | DEGREE | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| Michael B. Pearlman, M.D. | | | | | | 8726 Liberty Plaza
Randallstown, Md. 21133 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Entombment | | | May 9, 1979 | | | Meadowridge Mem Pk. | | | Elkridge Howard MD | | | | |
| 24 FUNERAL DIRECTOR
NAME <u>[Signature]</u> | | | | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| Singleton Funeral Home, Glen Burnie, Md. | | | | | | | | | MAY 8 1979 | | | <u>[Signature]</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10711

| | | | | | | | | |
|--|---|---|--|--|--------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| Sylvester Edward QUARLES (Quarries) | | | May 29, 1979 | | | 11:55P ^M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| Male | Black | May 25, 1929 | 50 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | USA | | | | Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | Anne Arundel General Hospital | | | Waterman | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Anne Arundel | | | Mayo | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| Fleetwood NMN Quarles | | | Sarah Etta Joyce | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| No | | | 216-22-3654 | | | Sarah Louise Quarries (wife), same | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u> - - - - - 1 year
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardiomyopathy</u> - - - - - unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Atherosclerotic, diabetic, & unknown causes</u> - - - - - | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic obstructive pulmonary disease</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| NA | | | NA | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 27</u> , 19 <u>79</u> , to <u>May 29</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>May 29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | | 22c. DATE SIGNED | | |
| 22b. SIGNATURE
<u>Charles W. Kinzer</u> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | May 30, 1979 | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 23b. ADDRESS | | | | | |
| Charles W. Kinzer, MD, PA | | | 16 Murray Ave. Annapolis, Maryland 21401 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| BURIAL | | | 6-2-1979 | | | St. Marks Church Ceme | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | 23e. DATE REC'D. BY REGISTRAR | | | 23f. REGISTRAR'S SIGNATURE | | |
| Mayo Maryland | | | MAY 31 1979 | | | <u>William Reese</u> | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| WILLIAM REESE & SONS MORTUARY, P.A.
Annapolis, Md. | | | MAY 31 1979 | | | <u>William Reese</u> | | |

BP



11701-05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR TO BE FILED AFTER DEATH. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VIR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10712

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--|--|---|--|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Arvine | | | | | | Queen | | 5 | | 13 | | 19 | | 79 | | M | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | Black | 3 28 49 | | 30 YRS. | | MONTHS | | DAYS | | 5 | | 13 | | 19 | | 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Wash., D.C. | | U.S.A. | | | | | | Anne Arundel County, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Annapolis | | Anne Arundel General Hospital | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Anne Arundel | | Annapolis | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 24 F Bens Dr. | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Thomas | | | | Anna | | | | Matthews | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| | | | | 212-48-0179 | | | | Pamela Queen, 24 F Bens Dr., Annapolis | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of chest | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | 12:30x 5 13 1979 | | | | subject shot during altercation | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | STATE | | | | | |
| | | | | street | | | | Clay Street | | | | Annapolis A.A. MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from | | | | | | | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
|  | | | | Deputy Chief | | | | 5/14/79 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Thomas D. Smith, M.D. | | | | 111 Penn St. | | | | Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Burial | | | | 5-17-79 | | | | Pinelawn Mem. Park | | | | CITY OR TOWN | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| NAME | | | | ADDRESS | | | | MAY 15 1979 | | | |  | | | | | |
| William Resse Funeral Home | | | | | | | | | | | | | | | | | |

10-10115

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William Bruce Winneti Rose

MAY 4 1915

[Handwritten signature]

Item #236 per phone call w/Fun.

1. FOR Home 5/31/79 re
STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10713

| | | | | | | | |
|--|--|---|---|--|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELWOOD E QUILLEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 26 1979 | | 2b. HOUR
2:08 PM | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 05 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. US Gov't Chauffeur | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Grasonville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elwood T. Quillen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hallie Bowden | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
228-18-2185 | |
| 17. INFORMANT
Jeanette A. Quillen | | ADDRESS
Same as 13 a-e | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Renal failure
7109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Mixed Connective Tissue Disease (probable)
DUE TO, OR AS A CONSEQUENCE OF
(c) unknown
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | | |

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | |
|--|--|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 79 , to 5/26 , 19 79 , that (I) have lost
saw the deceased alive on 5/26 , 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated
above, (I) was not (did not) view the body after death. | | | |
| 22b. SIGNATURE
R. I. Hochman, MD | | DEGREE
MD | |
| 22c. DATE SIGNED
5/27/79 | | 22d. ADDRESS
16 Murray Ave. Annapolis Md. 21401 | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
5-30-79 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | | 23d. LOCATION
Annapolis, Maryland STATE | |
| 24. FUNERAL DIRECTOR
Beall Funeral Home, 1212 West St., Annapolis, Md. | | 25. DATE REC'D. BY REGISTRAR
MAY 31 1979 | |
| 26. REGISTRAR'S SIGNATURE
Jeffrey McCready | | 27. REGISTRAR'S SIGNATURE | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 9-10714

| | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| SARAH | | NMN | | Rechis | | MAY 12 1979 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | White | MONTH DAY YEAR | | 3 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | Nov. 19, 1975 | | ANNE ARUNDEL Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Glen Burnie | | 8009 Crainmont Drive | | | | NONE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| md. | | AA. CO. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8009 Crainmont DR. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | NO | | NONE | | MR. SALVATORE J. Rechis (FATHER) | |
| SALVATORE J. Rechis | | SUZANNE M. Penleton | | N/A | | | | ADDRESS SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 2040 | | | | | | | | 2 1/2 hr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | 18 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| b) <u>Acute Lymphoblastic Leukemia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (i) this hospital attended the deceased from <u>Oct</u> 19 <u>78</u> , to <u>May</u> 19 <u>79</u> , that (ii) we last saw the deceased alive on <u>March 26</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death, so state). | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>Wm H Meyer</u> | | MD | | | | May 13, 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Wm H Meyer | | Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| Burial | | 13 MAY 79 | | Gunpowder Friends House | | SPARKS | | BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| G. J. Garton | | 12121 FENNER FUNERAL HOME, GLEN BURNIE | | MAY 15 1979 | | <u>Anthony Melchior</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10715

| | | | | | | | | | |
|--|---|---|--------|--|---|---|--------------------------|------------------|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR DST |
| PAUL Joseph REED, SR. | | | | | MAY 22, 1979 | | | | 9:02A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | |
| Male | White | MONTH DAY YEAR
FEB 22, 1898 | | 81 | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | | Self-Employed Plumber | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS |
| Maryland | | AnneArundel | | GlenBurnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 306 New Jersey Avenue | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | | | | |
| George | | Katherine | | Pasadena, Md. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | N/A | | Mrs. Marie Brown (Daughter) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Cerebral Terminal Bronchopneumonia</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral vascular insufficiency, severe</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COPD, ASCVD, Pharyngeal Abutitis</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| ANASTACIO E. SUBONG, M.D. | | | | | | | | 5/22/79 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Entombment | | 25 MAY '79 | | Lorraine Park | | Woodlawn Balto Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SINGLETON FUNERAL HOME, Glen Burnie, MD | | MAY 28 1979 | | Anthony McCreedy | | | | | |

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21701-05

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10716

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE STEVENS ROPER | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 16 79 | | 2b. HOUR
0555AM |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
4 13 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | 7 UNDER 1 YEAR
MONTHS DAYS
8 UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILL. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
HAWK HUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Hawthorn | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HAGGEN Hospt. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
INVESTOR | | 12b. KIND OF BUSINESS OR INDUSTRY
Property Mt. |
| 13a. STATE
MD | 13b. COUNTY
AA | 13c. CITY OR TOWN
Hawthorn | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
41 Sout Hgate Ave. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
MAURICE ROPER | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES MARSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
051146451 | | 17. INFORMANT
ADDRESS
MARY DAEBY ROPER #13 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Respiratory/Cardiac Arrest
 431-
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
 (b) Sub-Arterial-ventricular
 DUE TO, OR AS A CONSEQUENCE OF
 (c) hemorrhage

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 15 May 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John B. Gower MD | | DEGREE | | 22c. DATE SIGNED
16 May 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Gower | | 22e. ADDRESS
121 Cathedral St. Hawthorn, Mo. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
5/16/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln | |
| 23d. LOCATION
(CITY OR TOWN COUNTY STATE)
Brentwood PG, MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1979 | | | |
| 24. FUNERAL DIRECTOR
NAME
John M. Lyle, Jr. | | ADDRESS
Annapolis, Md | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP
DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the date of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19-10118

2. 10/24

III.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-10717 | | | |
|--|--|--|---|---|--|--|--|--|---|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
LULA MARIE MOORE ROSS | | | | | MAY 26 79 | | | | | 1:55AM | | | |
| 3. SEX
FEMALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR
MAY 12, 1916 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
63 YEARS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MUSICE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
MILLERSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
KNOLLWOOD MANOR NURSING | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALBERT S. J. MOORE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELLA JANE TAYLOR HOME | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
UNK. | | 17. INFORMANT ADDRESS
EMERGENCY ROOM CHART | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line to PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Left ventricular failure</u>
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uremia</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Uremia</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> 19 <u>79</u> , to <u>5/26</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Max Frank</u> DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
MAY 26, 1979 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MAX FRANK M.D. | | | | | 22e. ADDRESS
425 S.E. RITCHIE HIGHWAY GLEN BURNIE | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
REMOVAL | | | 23b. DATE
5-29-79 | | 23c. NAME OF CEMETERY OR CREMATORY
EAST ST. LOUIS ILL. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
EAST ST. LOUIS ILL. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
R. N. HORTON CO. MORTICIANS, 600 KENNEDY ST., N.W. D.C. | | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 31 1979 | | | | | | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION



79-10717

LULA MARIE MOORE BOSS MAY 22 1938 1:52A

FEMALE INFO MAY 10, 1938 27 YEARS

WINE ARNOLD COUNTY

GLENN BURNIE NORTH ARNOLD HOSPITAL

MARYLAND WINE ARNOLD HOSPITAL

ARMED & DANGEROUS

EMERGENCY ROOM CHART

MAY 22, 1938

BOB S.E. RITCHIE HIGHWAY GLEN BURNIE M.F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10718

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THOMAS E. ROST | | | 2a. DATE OF DEATH
MONTH MAY DAY 26 YEAR 1979 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH MAY DAY 28 YEAR 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS.
IF UNDER 1 YEAR: MONTHS 0 DAYS 0
IF UNDER 24 HRS: HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anna Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDHEL Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tool & Die Setter | | 12b. KIND OF BUSINESS OR INDUSTRY
Worthington |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Anna Arundel 13c. CITY OR TOWN Glen Burnie | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST John MIDDLE P. LAST ROST | | | 15. MOTHER'S MAIDEN NAME
FIRST Beatrice MIDDLE H. LAST Taylor | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
213-12-6232 | | 17. INFORMANT
NAME Helen E. Knight ADDRESS 312 7th Avenue N.E. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
2 yrs
10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. 11:00 MONTH May DAY 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, WORK OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET N/A CITY OR TOWN N/A COUNTY N/A STATE N/A | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-14-1965 to 5-24-1979 , that (I) (we) lost saw the deceased alive on 5-24-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
H.F. Manuzak MD | | DEGREE MD | | 22c. DATE SIGNED
5-29-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H.F. MANUZAK, MD | | 22e. ADDRESS
425 S.E. Ritchie, Glen Burnie Md 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/29/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Harford STATE Md | | 23e. DATE REC'D. BY REGISTRAR JUN 1 1979 | | | |
| 24. FUNERAL DIRECTOR
NAME Charles L. Stevens Funeral Home, Inc. ADDRESS 1501 E. Fort Ave. | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1979 | | | |

81101-03



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-10719

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|---|------------------|---|--|--|---|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Alice
XXXXXXXXXX | | FIRST Alice MIDDLE Rotruck LAST Rotruck
XXXXXXXXXX | | 2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 5 19 79 | | 2b. HOUR A M | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY 7 6 02
XX | 6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 19 79 | 2d. HOUR A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 11. CITY OR TOWN OF DEATH Glenn Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| 13a. STATE W. Va. | | 13b. COUNTY Mineral | | 13c. CITY OR TOWN Keyser | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 50 N. Davis St. | | 14. FATHER'S NAME FIRST MIDDLE LAST Obed F. Rotruck | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Michael | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | |
| 16a. SOCIAL SECURITY NO. 236 50 0392 | | 17. INFORMANT Mildred Cutter | | ADDRESS 50 N. Davis St. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) 4280
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(c) months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE E. Linhardt | | TITLE (SPECIFY) M.D. Report 9 | | MEDICAL EXAMINER | | DATE SIGNED 5-19-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt | | ADDRESS Annapolis, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 22 May 79 | | 23c. NAME OF CEMETERY OR CREMATORY Knobley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Martin Grant W. V. | |
| 24. FUNERAL DIRECTOR NAME Allen M. Rotruck | | ADDRESS Keyser, W. Va. | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | |

01701-0

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 79-10720
REG. NO. | | D.S.T. | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CLARA ANNA SCHNEIDER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 20, 1979 | | 2b. HOUR
3:50 A.M. | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 7, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY AnneArundel 13c. CITY OR TOWN Glen Burnie | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1607 Saunders Way | |
| 14. FATHER'S NAME
FIRST Gustav MIDDLE Spiegel LAST Spiegel | | 15. MOTHER'S MAIDEN NAME
FIRST Caroline MIDDLE Francke LAST Francke | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
366-16-9565 | | 17. INFORMANT
ADDRESS Severna Park, Md.
D Mr. Leonard G. Schneider (Son) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4/40 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) ASAD-
DUE TO, OR AS A CONSEQUENCE OF (c) ASAD-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/16/79 to 5/20/79 , that (I) (we) lost the deceased alive on 5/18/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22a. SIGNATURE
Jorge B. Ramirez | | 22b. ADDRESS
325 HOSPITAL DRIVE-SUITE 207
GLEN BURNIE, MARYLAND 21061 | | 22c. DEGREE
M.D. | | 22d. DATE SIGNED
5/20/79 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
23 MAY '79 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem.Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | |
| 24. FUNERAL DIRECTOR
NAME SINGLETON FUNERAL HOME ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony A. Crady | | | |

BP

CLASS

GLENN BURKLE

JOSEPH S. BARNES, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10721

| | | | | | |
|--|--|---|--|----------------------|------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | 20. MONTH DAY YEAR | | 11:20 P M | |
| LEO J SCHWARTZ | | 5 20 79 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR
June 11 06 | 72 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | U.S.A. | | ANNE ARUNDEL MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Glen Burnie | NORTH ARUNDEL HOSPITAL | Electrician | Shipyard | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | Anne Arundel | Glen Burnie | YES <input type="checkbox"/> NO <input type="checkbox"/> | 1519 Annapolis Drive | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | |
| John A. Schwartz | Caroline Tucker | 16b. SOCIAL SECURITY NO.
218-03-0168 | | | |
| 17. INFORMANT | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
5712
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Jaundice's cirrhosis with anemia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Adenocarcinoma of ascending colon.</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Ascites; Polyps of sigmoid colon</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 4/25/79 | Adenocarcinoma of ascending colon | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> 19 <u>79</u> to <u>5/20</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | | | |
| <i>B. C. de Guzman M.D.</i> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 5/21/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| de GUZMAN, BENJAMIN A. | 325 Hospital Dr. Glen Burnie, Md, 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Removal | 5/21/79 | | | | |
| 24. FUNERAL DIRECTOR | 25a. DATE READ BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
Anatomy Board Balto., Md. | JUN 1 1979 | <i>Benjamin A. de Guzman</i> | | | |

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COPIES
10-20-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
IRA L. Roy SCHYLASKE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 29, 1979 | | 2b. HOUR
8:30 AM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 28, 1908 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
General Construction | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Schylaske | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen Shadle | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
180-03-3578 | | 17. INFORMANT
Jennie Schylaske | | 17. ADDRESS
same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, right lung</u>
502-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>massive pulmonary fibrosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Silicosis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 weeks
years
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>77</u> , to <u>5/29</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 27b. SIGNATURE
Bernardino A. Alonso, M.D. | | | | 27c. DATE SIGNED
5/29/79 | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARDINO A. ALONSO, M.D. | | | | 27e. ADDRESS
1406 CRAIN HIGHWAY, S., #102
GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-2-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
McGully F.H. Mountain & Tick Neck Rds, Pas. Md. 21122 | | | | |
| 25a. DATE REC'D BY REGISTRAR
JUN 1 1979 | | 25b. REGISTRAR'S SIGNATURE
Dorothy McBrady | | | | |

79-10722

SS 101-01

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10723

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph M. SCRIBNER | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/24/79 | | 2b. HOUR
12:30A | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 14, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. J. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE ANN MDE | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | |
| 14. FATHER'S NAME
FIRST HENRY MIDDLE MYERS LAST SCRIBNER | | 15. MOTHER'S MAIDEN NAME
FIRST MARY MIDDLE LEE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
162164731A | | 17. INFORMANT
HELEN O. SCRIBNER #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest.
410 -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
1 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17/79 to 5/24/79 , that (I) (we) last saw the deceased alive on 5/17/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard P. Lee | | DEGREE
MD | | 22c. DATE SIGNED
5/24/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD P. LEE | | 22e. ADDRESS
121 Cathedral St. Annapolis MD | | 22f. DATE REC'D BY REGISTRAR
MAY 29 1979 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
5-24-79 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN | |
| 23d. LOCATION
(CITY OR TOWN)
BRENTWOOD | | COUNTY
DG MD | | STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
JOHN M. TAYLOR-SONS | | ADDRESS
ANNAPOILIS MD | | 25a. DATE REC'D BY REGISTRAR
MAY 29 1979 | |
| 25b. REGISTRAR'S SIGNATURE
Richard P. Lee | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

10-10153

RECEIVED



RECEIVED

10-10153

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-10724 | | | |
|--|--|--|--|--|--|---|--|-------------------------------------|--|--|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE OF DEATH
MONTH DAY YEAR | | | | 20. HOUR | |
| WALTER | | Theodore | | SERMONS | | | | MAY 16, 1979 | | | | 6:15 A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | Sept. 23 1906 | | 72 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U. S. A. | | | | ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Printer | | Reese Print Co. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | A. A. | | Severn | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1441 Watts Avenue | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| George | | Louisa | | Bartholmew | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (wife) | | ADDRESS | | | | | | | |
| no | | N/A | | 202015159A | | Mrs. Nettie E. Sermons | | Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | | | | | | | | | | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF <u>Ca of lung & metastasis</u> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-23</u> 19 <u>79</u> to <u>5/16</u> 19 <u>79</u> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| S. Eren | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| SACIT EREN, M.D. | | 529 CAMP MEADE ROAD
LINTHICUM, MARYLAND 21090 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | May 18, 1979 | | Mount Olivet Cem. | | Baltimore City, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Singleton Funeral Home | | Glen Burnie, Md. | | MAY 18 1979 | | [Signature] | | | | | | | |

BP

18-10724

OUTWARD MAIL

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REVENUE

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NORTH BRUNNELL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the vital records department.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

79-10725

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Cloyd F. Shields | | | 2a. DATE OF DEATH
Month 5 Day 4 Year 1979 | | | 2b. HOUR
8:20 A.M. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
January 11, 1901 | | 6. AGE (In years last birthday)
78 YRS | | IF UNDER 1 YEAR
MONTHS 7 DAYS 13 | | IF UNDER 24 HRS.
HOURS 8 MIN 20 | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
A.A. Co. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Anne Arundel Gen. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE
Penna. | | | 13b. COUNTY
Huntingdon | | 13c. CITY OR TOWN
Mill Creek | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME
First James Middle Augusta Last Shields | | | 15. MOTHER'S MAIDEN NAME
First Annabelle Middle Reed Last Reed | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
163-36-7566 | | 17. INFORMANT
Address Mrs Walter Filer Edgewater, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest & Coma
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) ACVD
DUE TO, OR AS A CONSEQUENCE OF
(c) Bilateral Bronchopneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5d
year
5d | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Obstructive Pulmonary Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. — Month — Day — Year 1979
P.M. — | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. — City or Town — County — State — | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-30-1979 , to 5-4-1979 , that (I) (we) last saw the deceased alive on 5-4-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Frank M. Shipley | | | | | | 22c. DATE SIGNED
5-8-79 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
F.M. SHIPLEY | | | | | | 22e. ADDRESS
Annapolis Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
— | | | 23b. DATE
5-7-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Newton Hamilton Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Newton Hamilton, Md. G. Pa. | | | |
| 24. FUNERAL DIRECTOR
Wayne L. Ross L. Booth Funeral Home | | | | | | 25a. RECORDING
MAY 11 1979 | | | 25b. REGISTERING
— | | |

MEDICAL CERTIFICATION

10-10322

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

(M)



10-10322

10-10322



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10726

| | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| HATTIE C. SHORTER | | | | | 5 | 4 | 79 | 12.05 | P |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | NEGRO | MONTH DAY YEAR
4 12 1922 | | | 57 | YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | U.S.A. | | | | Anne Arundel County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ANNAPOLIS | ANNE ARUNDEL GENERAL HOSPITAL | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| MARYLAND | A.A. | ANNAPOLIS | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10 College Avenue | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
LOUISE WEEMS | | | | | FIRST MIDDLE LAST
EDNA WILSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | | FLORENCE JUSTIN 706 D Newtown Dr. Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Longestive Heart Failure</u> | | | | | | | | | 2-3 mos |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>Recurrent Myocardial Infarctions</u> | | | | | | | | | 1974, 76, 79 |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | Present | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 79</u> to <u>Present</u> 19__, that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>Peter Verkouwen</u> | | | | | | | | 5-4-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| PETER F. VERKOWEN M.D. | | | | | 1419 Frost Drive, Annapolis, Md. 21403 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 5-9-1979 | | PINELAWN MEM. PARK | | Annapolis A.A. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | |
| WILLIAM REESE & SONS MORTUARY, P.A. | | | | | Annapolis, Md. | | MAY 11 1979 | | |

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MAY 1 1978

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10727 DST

| | | | | | | |
|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM R. SHORTT, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 11, 1979 | | 2b. HOUR
12:45PM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 1 1900 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
YEARS MONTHS DAYS
79 | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland A.A.C. Glen Burnie | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
105 Governors Ct. Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Shortt | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Marshall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO NA | | 16b. SOCIAL SECURITY NO.
215-07-7772 | | 17. INFORMANT
ADDRESS
Catherine M. Shortt same as 13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
DUE TO, OR AS A CONSEQUENCE OF CEREBROVASCULAR ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertension.
DUE TO, OR AS A CONSEQUENCE OF
(c) Accident | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-21 , 19 79 , to 5-11 , 19 79 , that (I) (we) lost saw the deceased alive on 5-11 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
DALJIT S. SAWHNEY | | | | 22c. DATE SIGNED
5/11/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DALJIT S. SAWHNEY, M.D. | | | | 22e. ADDRESS
21061 205 B&A BLVD., GLEN BURNIE, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/15/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Pk. Glen Burnie A.A.C. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
McGully E. H. of Pasadena 3204 Mountain Rd. | | 25. DATE REC'D. BY REGISTRAR
MAY 14 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10728

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ANGELA LOUISE SINCLAIR | | | 2a. DATE OF DEATH MONTH DAY YEAR
23 MAY 79 | | | 2b. HOUR
0924A.M. | |
| 3 SEX
FEMALE | | 4 RACE
CAUCA | | 5 DATE OF BIRTH MONTH DAY YEAR
28 MAR 79 | | 6 AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
YRS. 1 25 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH
FORT MEADE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KIMBROUGH ARMY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
FORT MEADE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
ROBERT LOUIS SINCLAIR | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JAKALINE ANN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A. | | 17 INFORMANT
Father | | ADDRESS
1851 C Patten Dr. Ft. Meade, MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CONGENITAL HEART DISEASE - type unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 Weeks
8 Weeks (birth) |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Prematurity | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 23 May 19 79 , to 23 May 19 79 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> view the body after death. (did) and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
<i>Steven A. Larson</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
23 May 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN A. LARSON, MAJ, MC | | | | 22e. ADDRESS
20755 KIMBROUGH ARMY HOSPITAL, FT. MEADE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Milo, Piscataquis, Maine | |
| 24 FUNERAL DIRECTOR
FLECK LARUEL FUNERAL HOME, INC. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>L. J. Halbury</i> | |
| 26 ADDRESS
7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | | | | |

BP

50-10150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-10729
REG. NO. | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRED SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 23 1979 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 2 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BONE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.A. GEN. HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY
CONST. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
AA. | 13c. CITY OR TOWN
ARNOLD | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
103 CHURCH RD. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Augusta SMITH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MINNIE KOPECK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WWF 217056450 | | 17. INFORMANT
ADDRESS
CLARICE E. SMITH #13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
496-
DUE TO, OR AS A CONSEQUENCE OF (b) CH. OBST. LUNG DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (and) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. Hislop | | DEGREE | | 22c. DATE SIGNED
5-23-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. HISLOP | | 22e. ADDRESS
ROBINSON RD SEVERNA PK MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-26-79 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY
GLEN BURNIE AA MD. | | 23e. DATE REC'D. BY REGISTRAR
MAY 31 1979 | | 23f. REGISTRAR'S SIGNATURE
Robert M. Brady | |
| 24. FUNERAL DIRECTOR
NAME
JOHN M. TAYLOR-SONS | | ADDRESS
ANNAPOLIS MD. | | | |

BP

8-10552

(M)

X

Robinson R. Governor of MD

2-25-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|---------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. 79-10730 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SARAH R. SMITH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 27 79 | | | | | 2b. HOUR
6:30 AM |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
2 19 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL CO. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Cheschtan | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5704 N. SHORE PKWY. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Holden | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Russell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES)
579-60-6778 | | 17. INFORMANT ADDRESS
Donald Smith, Son, Same as Above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intractable Chronic Cong. Heart Failure 1 year
4240 DUE TO, OR AS A CONSEQUENCE OF (b) Mitral Insufficiency 1+ year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Old CVA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FALL 1978 to Present 1979, that (I) (we) last saw the deceased alive on 5-22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Peter F. Verkouw | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/28/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUW | | | | 22e. ADDRESS
1419 FOREST DRIVE, ANNAPOLIS, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-30-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Bladensburg, P.G., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
Robt E Wilhelm | | | | ADDRESS
4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

10-10130

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10731

1 - STATE
REGISTRAR

| | | | | | |
|---|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ellen Lois Solomon | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-14-79 | | 2b. HOUR
1:50 A M |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
2-15-37 | | 6 AGE (IN YEARS LAST BIRTHDAY)
42 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
AA Co MD | |
| 10 CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
AA General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Medical Asst | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | | 13b. COUNTY
AA Co | 13c. CITY OR TOWN
Annapolis | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William Plaine | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Greenfield | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 34 5412 | | 17 INFORMANT ADDRESS
Selig Solomon,, #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ca Bariat</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>72</u> to <u>5-14</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see anybody after death. | | | | | |
| 22b. SIGNATURE
<u>S. Watkins</u> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>S. Watkins</u> | | | | 22e. ADDRESS
<u>Annapolis Md 21401</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-15-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Kneseth Israel | |
| 24 FUNERAL DIRECTOR
NAME
Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401 | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
MAY 16 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>L. H. H. H. H. H.</u> | |

10-1031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10732

| | | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|-----------------------------------|---|--|-----------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BERTIE R. SPENCER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 30, 1979 | | 2b. HOUR DST
9:50A M | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 7, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS.
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6658 Roberts Ct. | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ruby | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
217 12 6155 | | | 17. INFORMANT
ADDRESS Pasadena, Md.
Thelma D. Cox, 172 Lake Shore Dr., | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congenital Heart Failure</u>
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) <u>Arteriosclerotic Heart Disease</u>
(c) <u>Due to, or as a consequence of</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
WHILE <input type="checkbox"/> AT HOME | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. certify that (I) (this hospital) attended the deceased from <u>5/4/79</u> , 19____, to <u>5/30/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>5/29/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jorge B. Ramirez</u>
JORGE B. RAMIREZ, M.D. | | | | | | DEGREE
M.D. | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED
5/30/79 | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE B. RAMIREZ, M.D. | | | | | | 22f. ADDRESS
325 HOSPITAL DRIVE, #207
GLEN BURNIE, MARYLAND 21061 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6/2/79 | | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Geo. J. Gonce, 4001 Ritchie Hg., Baltimore | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1979 | | | 25b. REGISTRAR'S SIGNATURE
<u>Robert McCreedy</u> | | | | | |

BP

SET 01 - P 8



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10733

1 - FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY ELIZABETH SWONGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 26, 1979 | | | 2b. HOUR
DST
3:15AM | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 19, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 yrs YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 8. IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- - | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Glover | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Turiell | | | 16. STREET ADDRESS
1123 Leonard Dr. (21061) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- - | | 17. INFORMANT
Mr. William Swonger | | 18. ADDRESS
4315 Buchanan Ave 21211 | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
436-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) ACCIDENT | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Fracture hip | | | | | | | | |
| 19a. DATE OF OPERATION
1123179
414179 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fracture hip | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 15 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Fell at Home - Fracture hip | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1123 Leonard Drive Glen Burnie MD | | 21g. DATE SIGNED
5/26/79 | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 22, 1979 to May 26, 1979 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/26/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE B. RAMIREZ, M.D. | | | | 22e. ADDRESS
325 HOSPITAL DR. SUITE 207 GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/28/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion United Meth Church, Freeland, Balto, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Freeland, Balto, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
A. Aaln Seitz Funeral Home 3818 Roland Ave. | | | | 25a. DATE RECEIVED BY
JUN 5 1979 | | 25b. SIGNATURE
[Signature] | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

58-10533



WINE PRINCE OF WALES

WINE PRINCE OF WALES

WINE PRINCE OF WALES

WINE PRINCE OF WALES

WINE PRINCE OF WALES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10734

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Jane M Thayer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 14 1979 | | 2b. HOUR
4 p.m. |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 19 1949 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
JAPAN | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | | 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. Hosp. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RAYMOND EDWARD THAYER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Patricia MARTIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-64-1392 | | 17. INFORMANT
ADDRESS
R.E. THAYER #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Melanoma
1729
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4 19 79 , to 5/14 19 79 , that (I) (we) lost
saw the deceased alive on 5/4 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Enser W. Cole III MD | | DEGREE | | 22c. DATE SIGNED
5/14/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ENSER W. COLE III | | 22e. ADDRESS
121 CATHEDRAL ST ANNAPOLIS Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
5/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BREENWOOD PG. MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
John M. L. Hoxby | | ADDRESS
Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Patricia Hoxby | |

BP

101-101

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



3

U. S. DEPT. OF AGRICULTURE

OFFICE OF THE CHIEF OF BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10735

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|---|--|----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Josephine Funk Thurn | | | 2a. DATE OF DEATH MONTH DAY YEAR
5/3/79 | | 2b. HOUR
9:30 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
5-30-94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BAY MANOR NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
MD. | | 13b. COUNTY
A. PRINCE | | 13c. CITY OR TOWN
PASADENA | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Funk | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Nagel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-10-1936 | | 17. INFORMANT (daughter) ADDRESS
Mrs. Jacqueline B. Eaton # 13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction due to a stroke
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) A.S.R.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-2-1977 , to 5-4-1979 , that (I) (we) last saw the deceased alive on 5-2-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Emilia H. Wilson | | DEGREE
MD | | 22c. DATE SIGNED
5/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/7/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem. | |
| 24. FUNERAL DIRECTOR NAME
R. N. Hopkins | | ADDRESS
Singleton Funeral Home Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 8 1979 | |
| 25b. REGISTRAR'S SIGNATURE
Jeffrey McBrady | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

BP

28-10332

• • • • •

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10736

| | | | | | |
|--|---|--|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT) William H. Tracey, Sr. | | | 2a DATE OF DEATH
MONTH 5 DAY 4 YEAR 79 | | 2b HOUR
12³⁰ PM |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH 12 DAY 4 YEAR 08 | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10 CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b KIND OF BUSINESS OR INDUSTRY
picture Oper. |
| 13a STATE
Maryland | | 13b COUNTY
Anne Arundel | 13c CITY OR TOWN
Annapolis | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS
112 Carroll Drive, |
| 14 FATHER'S NAME
FIRST Edgar MIDDLE Tracey LAST Tracey | | 15 MOTHER'S MAIDEN NAME
FIRST Ella MIDDLE Caldwell LAST Caldwell | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
none | 17 INFORMANT
Mildred S. Tracey-wife-(same as 13e) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Failure
496-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Severe COPD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 5/4 79 , to 5/4 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Joseph N. Friend M.D. | | 22c DEGREE
M.D. | | 22e DATE SIGNED
5/4/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | | 22f ADDRESS
1616 Forest Dr. Annapolis, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b DATE
May 8, 1979 | 23c NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d LOCATION
CITY OR TOWN Sil, Spr. Montgomery COUNTY Md. STATE | |
| 24 FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25 DATE REC'D BY REGISTRAR
MAY 10 1979 | | 25 REGISTRAR'S SIGNATURE
Robert M. [Signature] | |
| 8434 Ga. Ave., S.S. Md. | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28-10138

(M)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 78-10737

| | | | | | |
|---|---|--|--|--|---|
| 1. STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Paul Ray Turner, Jr. | | 2a. DATE KNOWN OF DEATH: 5-12-79 | | 2b. HOUR: 12 M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 8/13/38 | 6. AGE (IN YEARS): 40 | 7. IF UNDER 1 YR. MONTHS: 0 DAYS: 0 | 7. IF UNDER 24 HRS. HOURS: 0 MIN: 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED: <input type="checkbox"/> WIDOWED: <input type="checkbox"/> DIVORCED: <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH: A.D. Co. MD. | | |
| 10. CITY OR TOWN OF DEATH: Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS): Church St. Stage Line | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Minister | 12b. KIND OF BUSINESS OR INDUSTRY: Baptist Ch. | | |
| 13a. STATE: Maryland | 13b. COUNTY: AnneArundel | 13c. CITY OR TOWN: Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS: 514 Marion Road | |
| 14. FATHER'S NAME: Paul Ray Turner, Sr. | | 15. MOTHER'S MAIDEN NAME: Jane Brewton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.: 263-54-6378 | | 17. INFORMANT: Mrs. Jeannine E. Turner (wife) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 9534 IMMEDIATE CAUSE (a) gun shot wound skull DUE TO, OR AS A CONSEQUENCE OF (b) Stutter DUE TO, OR AS A CONSEQUENCE OF (c) Stutter | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Stutter | | | | | |
| 19a. DATE OF OPERATION: 5-12-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? gun shot wound skull | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY: 5:12 P.M. MONTH: 5 DAY: 12 YEAR: 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): gun shot wound skull | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Church | | 21f. LOCATION: Stages Road & the highway at the MD | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE: E. Linhardt | | TITLE (SPECIFY): Deputy | | DATE SIGNED: 5-12-79 | |
| EXAMINER'S NAME (TYPE OR PRINT): E. Linhardt | | ADDRESS: Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: May 15, 1979 | 23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery | 23d. LOCATION: Tallahassee, Leon, Fla. | | |
| 24. FUNERAL DIRECTOR: SINGLETON FUNERAL HOME, GLEN BURNIE | | 25a. DATE REC'D. BY REGISTRAR: MAY 15 1979 | | 25b. REGISTRAR'S SIGNATURE: Tracy McCreedy | |

10-10-31

2-12-31
2-12-31

11/12

11/12 to 11/12
11/12 to 11/12

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11/12 to 11/12
11/12 to 11/12

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-10738

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN ANN VASICEK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 10 79 | | 2b. HOUR
M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
November 12, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | |
| 10. CITY OR TOWN OF DEATH
Brooklyn Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Home = 5708 Redmond Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Brooklyn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
5708 Redmond Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Jiricek | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
322 12 2238 | 17. INFORMANT ADDRESS
Rostislav J. Vasicek same as 13 e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary Fibrosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
515- _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 weeks
35 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Advanced Malnutrition.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) the hospital attended the deceased from 1977, 19, to death, 19, that (b) I saw the deceased alive on above, (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) and that in (my) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE
C. F. Fuhemann | | DEGREE | | 22c. DATE SIGNED
5/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. F. Fuhemann | | 22e. ADDRESS
South Baltimore General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/12/79 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | ADDRESS
4001 Ritchie Hwy | 25a. DATE REC'D. BY REGISTRAR
MAY 15 1979 | | 25b. REGISTRAR'S SIGNATURE
H. J. McCreedy |

BP

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8C101-05

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10739
DSYFOR
1. STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSE EMILY WALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 30, 1979 | | 2b. HOUR
2:50
A. M. |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | 7b. CITIZEN OF WHAT COUNTRY?
England | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY
MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
gift wrap. | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. St. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY
AA | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
406 Vernon Ct. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Allington | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emily Burton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
XXXXXXXXXX 214/46/1514 | 17. INFORMANT
ADDRESS same as 13
Mrs. Jean M. Colvin (daughter) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4241
DUE TO, OR AS A CONSEQUENCE OF
(b) Aortic Stenosis - CHF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Calcification of Aortic Valve
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
Years
Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/30 , 19 79 , to 5/30 , 19 79 , that (I) (we) last saw the deceased alive on 5/30 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
David A. Schwartz | | | | 22b. DATE SIGNED
5/30/79 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. SCHWARTZ, M.D. | | | | 22d. ADDRESS
325 HOSPITAL DRIVE, SUITE 201
GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Cremation | | 23b. DATE
May 30, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Balt. MD | | 23e. DATE REC'D. BY REGISTRAR
MAY 31 1979 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Singleton Funeral Home, Glen Burnie, MD | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



5208

TIME

1111

0701 02 YAM

0310

25

ANKER BRUNDEL COUNTY

GLEN BURNIE

NOV 19 1964

DAVID A. SCHWARTZ M.D.

GREEN BUSHLET, HUBBARD AND STODOL
352 HOSBLET, DRIVE, ZUTILE 301

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10740

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EMMA CHRISTINA WARE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 15 1979 | | | 2b. HOUR
1:35 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9-25-1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MD. | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
586 Sixth St. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Lehl | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherina Schaeffer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
213-05-8408 | | 17. INFORMANT
Mrs. Audrey Gossman - Same as Sec 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>
410 -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>AS CVD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>log</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-15-79</u> to <u>5-15-79</u> , that (I) (we) last saw the deceased alive on <u>5-15-79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-15-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. ARMAN | | | | 22e. ADDRESS
5700 Old COURT RD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-18-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD. | |
| 24. FUNERAL DIRECTOR
NAME
Robert S. Barranco | | | | ADDRESS
501 Ritchie Ave
Severna Park | | 25. DATE RECEIVED BY REGISTRAR
MAY 21 1979 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

01701-01

MAY 23 1947

WARE

CHRISTINE

EMMA

ANNE ARUNDEL

GLEN DUNNIE - NORTH ARUNDEL HOSPITAL

MAY 23 1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-10741

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN MILTON WEAVER, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 3, 1979 | | | 2b. HOUR DST
3:15P M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 1, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (RET.)
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BOILER MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
B&O R.R. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GLENBURNIE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
105 LEYMAR ROAD | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AUGUST WEAVER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CAROLINE ZINK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
n/a | | 17. INFORMANT
ADDRESS Same as #
MR. ROBERT A. WEAVER (SON) 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>
492-
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Emphysema</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>RBBB with Left Axis Deviation, Dehydration</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>79</u> , to <u>5-3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>S. Khatiani</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>5-4-79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SWADESH K. BHATIANI, M.D. | | | | 22e. ADDRESS
205 BALTIMORE ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAY 7 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
SINGLETON FUNERAL HOME, ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 8 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>D. J. McCreedy</u> | | | |

BP

10-10741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10742

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) DANIEL FANCIS WEIKERT | | LAST WEIKERT | | DATE OF DEATH MONTH DAY YEAR 5 18 79 | | 2b. HOUR 4:43 P.M. | |
| 3. SEX male | 4 RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 7 22 46 | | 6 AGE (IN YEARS LAST BIRTHDAY) 32 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | | | |
| 10 CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 12a. USUAL OCCUPATION CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | |
| 13a STATE MD | 13b COUNTY A.A. | 13c CITY OR TOWN Harwood | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 4373 Sohomons Is. Rd. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST DANIEL F WEIKERT Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SEARS | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. 218 42 9389 | | 17. INFORMANT ADDRESS LYLE C. WEIKERT #13 | | | |

MEDICAL CERTIFICATION

| | | |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest -
4290
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Myocarditis -
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1975 |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|--|---|
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 4/27 19 79 , to May 18 19 79 , that (I) (we) last saw the deceased alive on 4/27 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Rodney L. Brimhall MD | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 5/19/79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY L. BRIMHALL | | 22e. ADDRESS Forest Dr. Annapolis MD. | |

| | | | |
|--|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/24/79 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion | 23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Zion AA MD. |
| 24a. FUNERAL DIRECTOR John M. Lytle, Assoc. Congor, md. | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1979 | 25b. REGISTRAR'S SIGNATURE Henry McCreedy |



280

1997

42334 8 132154

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10743

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
Verdella P. White | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 12 79 | | 2b. HOUR
7:05 P.M. | |
| 3 SEX
Female | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
May 6 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10 CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
SEVERNA PARK | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ISIAH PACK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
STELLA PACK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-16-3030 | | 17. INFORMANT
ADDRESS
Severna Pk, Md.
ORESSA MORROW Rt. 1 P.O. Box 406 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metastatic Car of The Colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Dec 1977</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>None</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>11/12/77</u> to <u>11/12/77</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James Chacana</u> | | DEGREE
MD | | 22c. DATE SIGNED
11/12/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-17-79 | | 23c. NAME OF CEMETERY OR CREMATORY
CARPENTER HILL CEME. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Round Bay Maryland | | 23e. DATE REC'D. BY REGISTRAR
MAY 15 1979 | | 23f. REGISTRAR'S SIGNATURE
<u>Anthony Kennedy</u> | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | ADDRESS
Annapolis, Md. | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

12-10743

Page 6 1903

12-10743

12-10743

12-10743

Item 3 8331 5/21/79 gj

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10744

DST

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ESTELLE G. WIEST | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 10, 1979 | | | 2b. HOUR
635P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 25, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Severna Pk. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanislaw Gembicki | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Antoniette Gardocka | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16a. SOCIAL SECURITY NO.
215-07-9813 | | | 17. INFORMANT
Sister: Alfreda Sabins | | | 17. ADDRESS
Severna Pk. Md. 21146 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Cancer of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes
8 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 17 19 79 to May 8 19 79 , that (II) (we) lost
saw the deceased alive on May 8 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James G. Chaconas
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
5/11/79 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES G. CHACONAS | | | | | | 22c. ADDRESS
1521 RITCHIE HWY ARNOLD, MD. 21012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
May 14 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1979 | | 25b. REGISTRAR'S SIGNATURE
Barney McCreedy | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

WIST

ESTELLE

Jan. 22, 1912

WINE PRUNDEL

OLEN DUMIE NORTH ARDU DEL HOSPITAL

Handwritten notes and signatures are visible in the lower half of the page, including a large signature that appears to read "James G. Chagnas".

JAMES G. CHAGNAS 1901 RITCHIE HWY ARNOLD, MD. 21012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M/7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10745
REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Clarence J Wilson | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/7/79 | | 2b. HOUR
6:30 PM | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
6 28 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT INSURE FACILITY, GIVE STREET ADDRESS)
A. A. F. H. Hospt. | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
CIVIL SERVICE | | 12b. KIND OF BUSINESS OR INDUSTRY
Ret. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | 13b. COUNTY
AA. | 13c. CITY OR TOWN
Mayo | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
902 Selby Blvd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES B. Wilson | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIRGINIA Jordan | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | |
| 16b. SOCIAL SECURITY NO.
218 163117 | | 17. INFORMANT
ADDRESS
DORINE Wilson # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Arrest -
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary Artery Disease. Lung Stenosis
(c) Arteriosclerosis. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 72 to 5/7 19 79, that (I) (we) last saw the deceased alive on April 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Rodney E. Brumfield M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/7/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RODNEY E. Brumfield | | 22e. ADDRESS
Forest Dr. Annapolis MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/10/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. ANDREWS | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mayo AA MD | | 23e. DATE RECEIVED BY CLERK
MAY 11 1979 | | | |

24-10-1952

RECEIVED
10-10-1952



10

(M)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-10746
REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Myrthe C. Young | | | 2a DATE OF DEATH
MONTH DAY YEAR
5 18 79 | | 2b HOUR
A M
A |
| 3 SEX
F | 4 RACE
W | 5 DATE OF BIRTH
MONTH DAY YEAR
11 27 1886 | 6 AGE (IN YEARS LAST BIRTHDAY)
92 | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
YRS. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10 CITY OR TOWN OF DEATH
ANNAPOLIS | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNAPOLIS NURSING HOME | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a STATE
MD. | 13b COUNTY
AA | 13c CITY OR TOWN
ANNAPOLIS | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS
133 LEE DR. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN COHLISON | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY ELIZABETH DAVIS | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
- | 17 INFORMANT
ADDRESS
W. IRVIN YOUNG # 13 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>
<u>431-</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>CEREBRAL ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>15 MINUTES</u>
<u>10 YRS</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8-9-79</u> to <u>6-18-79</u> , that (we) lost
saw the deceased alive on <u>24 MAR 19 79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>Edward S. Beck MD</u>
DEGREE
PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD S. BECK | | | | 22c DATE SIGNED
<u>5-18-79</u> | |
| 22d ADDRESS
<u>FOREST DR ANNAPOLIS MD.</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b DATE
<u>5/21/79</u> | 23c NAME OF CEMETERY OR CREMATORY
<u>CEDAR BLUFF</u> | | 23d LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS AA MD. | |
| 24 FUNERAL DIRECTOR
NAME
<u>John M. Lytton</u> | | ADDRESS
<u>Chimney Mal.</u> | | 25a DATE REC'D BY REGISTRAR
<u>MAY 24 1979</u> | 25b REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

BP

